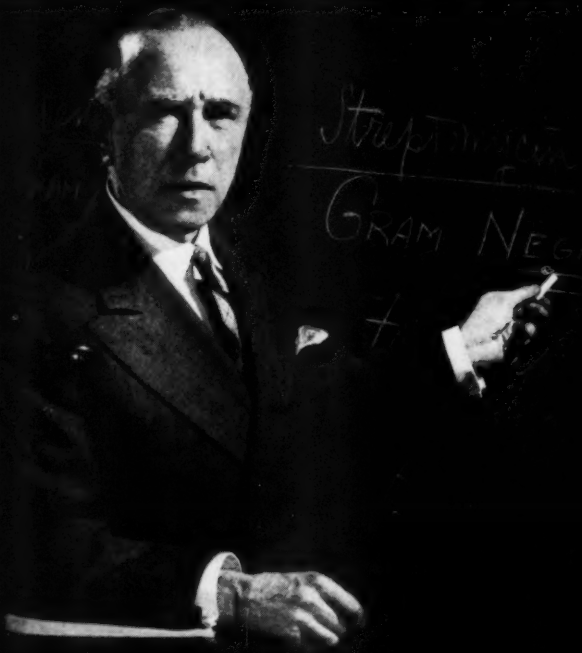
Medical Economics

MARCH



POST-GRADUATE MEDICAL EDUCATION . . . See page 55

Penicillin BY MOUTH

EFFECTIVE • SAFE • CONVENIENT

● *Systemic Therapy*

Tablets **PENIORAL**
TRADE-MARK

Buffered Penicillin. 25,000 units of penicillin calcium with sufficient trisodium citrate to buffer average gastric chyme. POTENCY PROTECTED, the tablets are packed in sealed vials containing a desiccant to insure full strength. *Twelve tablets each.*

Liquid **AMPHOCILLIN**
TRADE-MARK

Penicillin with Aluminum Hydroxide Gel. Each package contains 300,000 units penicillin calcium (dried) and 3 fluidounces of Aluminum Hydroxide Gel (Amphojel*).

● *Local Therapy*

Troches **BUCILLIN**
TRADE-MARK

Immediate, soothing, local action in the treatment of Vincent's infection. Each troche contains 500 units penicillin. Individually wrapped in moisture-proof metallic foil. *Boxes of twelve.*

WYETH INCORPORATED • PHILADELPHIA 3 • PA.

Medical Economics

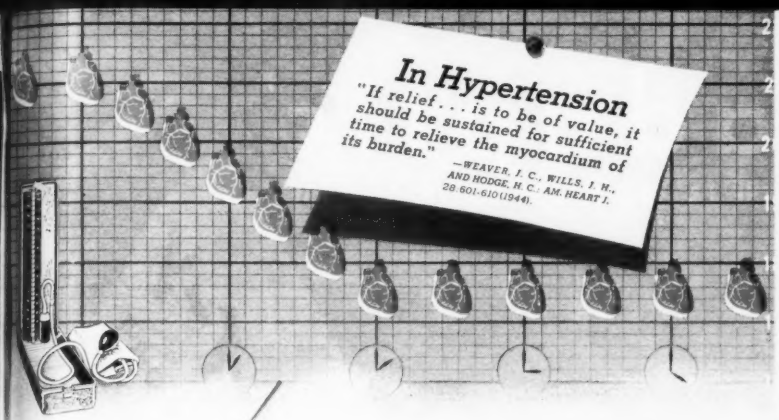
THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

MARCH 1946

Cover by Medical Photo Service

CIRCULATION 119,000

H. Sheridan Baketel, A.M., M.D., Editor-in-Chief. William Alan Richardson, Editor. Ross C. McCluskey, Managing Editor. Lansing Chapman, Publisher. W. L. Chapman, Jr., Business Manager. R. M. Smith, Sales Manager. 25c a copy; $2 a year (Canada and Foreign, $2.50 a year).



Maintaining lowered blood pressure over a more prolonged period...

NITRANITOL

BRAND OF MANNITOL HEXANITRATE

By its gradual, prolonged hypotensive action, *Nitranitol relieves the myocardium* of its burden, greatly lessens the danger of arterial damage and permits a resumption of regular activities.

There is no precipitate fall in blood pressure with Nitranitol, and its action is so prolonged as to permit maintenance of a continuous reduced pressure. Nitranitol can be used over extended periods of time without toxic manifestations; it does not produce nausea, and headache is rare.

Indications: Nitranitol is indicated in idiopathic arterial hypertension, for relief of such symptoms as headache, vertigo, palpitation, dyspnea, numbness, *arrhythmia, etc., and for prevention* of angina pectoris attacks, especially in patients suffering nocturnal seizures.

Average Dosage: One to two tablets every 4 to 6 hours. Nitranitol is available at prescription pharmacies in bottles of 100 and 1000 tablets. Each scored tablet contains ½ gr. mannitol hexanitrate.

Nitranitol with Phenobarbital
For cases requiring sedation in addition to vasodilation, ½ gr. Nitranitol is combined with ¼ gr. phenobarbital. Supplied in bottles of 100 and 1000.

Trademark "Nitranitol" Reg. U. S. Pat. Off.

MERRELL
116th Year

THE WM. S. MERRELL COMPANY · CINCINNATI, U. S. A.

Panorama

▶ Doctors as well as tradesmen are of necessity helping to finance long-drawn-out strikes by supplying services on a credit basis . . . Some 4,015 U.S. physicians died in 1945. Of the 2,962 whose obituaries appeared in the Journal AMA, 54 had been mayors, 23 bank presidents, 11 missionaries, seven postmasters, five dentists, four lawyers, and one each a U.S. Senator, minister to Liberia, and police commissioner . . . New general practice sections continue to be established by state and county medical associations. Latest: Indiana and Los Angeles . . . General Hawley foresees demobilized medical officers, discouraged by lack of office space, encouraged to join V.A. medical corps . . . Southwestern Medical College, Dallas, has awarded bronze plaque to the Medical Service Society, organization of local pharmaceutical men, for raising $38,500 in a building drive.

▶ New, multi-million-dollar medical school is planned by University of California . . . Newspaper readers were mildly startled by a report that the Consolidated Car Heating Company had been linked with some 200 dental laboratories in a charge of having violated anti-trust laws. Consolidated makes ticonium, a substitute for gold in dental practice . . . Political columnist John O'Donnell demands that prior to a Presidential election each party give the public "an honest picture" of the state of health and the life expectancy of its candidate . . . When Cleveland police reported theft of more than 100 physicians' bags containing narcotics from parked cars, the city's bureau of narcotics warned doctors that their narcotic licenses might be revoked if their carelessness contributed to such thefts . . . Allied authorities a month ago were still seeking some 30 Nazi doctors responsible for the extermination of 600,000 unemployable Germans between 1939 and 1945.

▶ Los Angeles County Civil Service Commission posted two jobs to be filled: kitchen helper, $144 to $171.60 a month; resident physician, $157.20 to $188.40 a month . . . Between 3 and 4 per cent of the total sales of drug manufacturers in 1944 ($12 million to $16 million) was devoted to research, says American Pharmaceutical Manufacturers Association . . . Private hospitals are vulnerable to damage suits, the California Supreme Court has

It is *Performance* in the Baumanometer

The keynote of Baumanometer superiority is Performance . . . the unfailing ability to provide accurate, trouble-free bloodpressure service. Performance and the inherent accuracy of this true mercury-gravity instrument logically recommend it as *the instrument of choice.*

Moreover, each Baumanometer has its own identifying number. The one that you now have or are going to buy, is individually calibrated and individually guaranteed . . . *to you. Your* Baumanometer is guaranteed to be scientifically accurate and to remain so . . . it is guaranteed against glass breakage for *your* lifetime . . . its proper Performance is guaranteed . . . *to you.*

No wonder that hundreds of thousands of Baumanometers have served the profession, the world over, for more than a quarter of a century.

The finest Baumanometers ever made are now obtainable from your surgical instrument dealer.

Get the **FACTS** *and you will buy a Lifetime Baumanometer*

W. A. BAUM CO., INC. NEW YORK 1

SINCE 1916

ORIGINATORS AND MAKERS OF BLOODPRESSURE APPARATUS EXCLUSIVELY

ruled, if they do not take adequate precautions to prevent an irresponsible patient from inflicting injuries on himself . . . A gynecologist has been employed by the Veterans Administration for the first time in its history. She is Lieut. Col. Margaret D. Craighill, formerly an Army consultant . . . Illustrious medical illustrator, Tom Jones, has prepared a course for Cazenovia (N.Y.) Junior College and will accept its graduates for advanced training in medical illustration.

▶ Of 85 Blue Cross plans, 45 are affiliated with medical prepayment plans . . . Medical Toastmasters, organization of New Orleans physicians, has been chartered by Toastmasters International . . . Consent decree signed by Wisconsin Alumni Research Foundation puts vitamin D patents in the public domain, averts anti-trust action threatened by U.S. Attorney General's Office . . . New plastic "iron lung" developed by Consolidated-Vultee Aircraft Company weighs only a fraction of steel devices and is said to be equally efficient . . . Sister Kenny documentary film, showing her method of treating polio victims, has been completed in England and will soon be distributed here . . . Definition from St. Louis County Medical Society Bulletin: "A general practitioner is a doctor who burns up 87 cents worth of gas to earn a $3 fee which he may never get."

▶ Army is commissioning 5,000 young M.D.'s to replace, by July 1, medical officers eligible for discharge . . . All but 4,000 of 41,000 doctors commissioned in the Army from civilian life will be out by June 30 . . . U.S. Office of Education will distribute revised edition of its most popular pamphlet, "What Every Teacher Should Know About the Physical Condition of Her Pupils" . . . Program of the District of Columbia Medical Society's committee on service veterans includes meetings where demobilized doctors can get up and make complaints and suggestions. The committee has already succeeded in having at least one small office building reconverted for the exclusive use of ex-service physicians.

▶ Among sponsors of the $2,000,000 penicillin plant to be built in Russia by the Hugh Cabot Memorial Fund are Mrs. Franklin D. Roosevelt, Thurman W. Arnold, Charles Kettering, Dr. J. Robert Oppenheimer, and Igor Sikorsky . . . Two thousand discharged medical officers were asked recently by this publication, "Do you expect to practice in a group or partnership?" Their response: No, 72 per cent; yes, 27 per cent; don't know, 1 per cent. Among those who answered yes, 40 per cent said they intended to practice with one associate; 27 per cent, with two or three associates; 19 per cent, with more than three; 14 per cent weren't sure . . . Recent Associated Press poll of 75 Republican and 63 Democratic Congressmen revealed them to be against a Federal compulsory sickness insurance program in the ratio of 7:4.

There is a Doctor in the House

—and it took a minimum of $15,000 and 7 years' hard work and study to get him there!

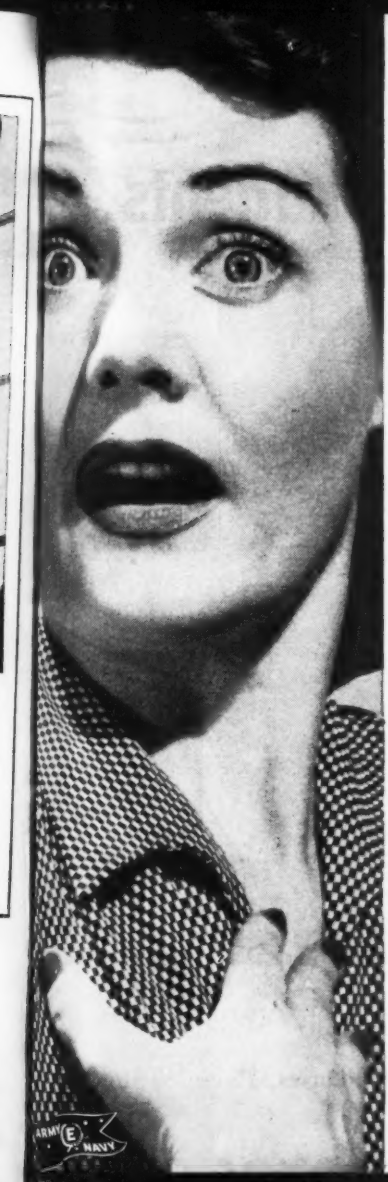
● Proudly he "hangs out his shingle," symbol of his right to engage in the practice of medicine and surgery. But to a doctor it is more than a right: it is a privilege—the privilege of serving mankind, of helping his fellow man to a longer, healthier, and happier life.

According to a recent nationwide survey:

More Doctors Smoke Camels

than any other cigarette

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.



Detect Malignancies Before It Is

Too late!

THE VALUE OF the National Body Cavity Set is acknowledged by leading surgeons, gynecologists, and general practitioners. Its use creates patient *confidence;* and its availability *encourages frequent examinations* of *all* body cavities, assuring diagnosis of malignancies before it is too late for successful surgical intervention.

The "National" is most versatile! All sizes of tubular specula are quickly interchangeable. One adjustable illuminating system—one handle—one magnifying telescope—one insufflator—for all sizes of tubular specula. Light beam is adjustable for parallel, converging or diverging rays. Boilable, insulating "Neiromold" construction provides absolute safety for instrumentation, cauterization and desiccation.

National
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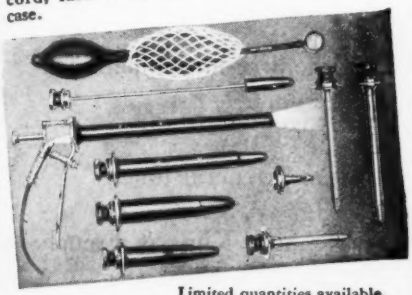
For All Cavities • All Ages • Both Sexes

THE N101 SET: Includes "Neiromold" sigmoidoscope, proctoscope, child proctoscope, anoscope, tubular vaginal speculum, "virgiscope," urethroscope, skenescope, handle grip, light carrier with cord, insufflator and telescope; in walnut case.



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— neither seriously ill,
nor yet entirely well —
who often respond dramatically
to the administration
of a good tonic.

ESKAY'S NEURO PHOSPHATES
and
ESKAY'S THERANATES
— palatable,
easily tolerated
tonic preparations —
help restore appetite,
vigor
and general tone.

The convalescent

Smith, Kline & French Laboratories, *Philadelphia, Pa.*

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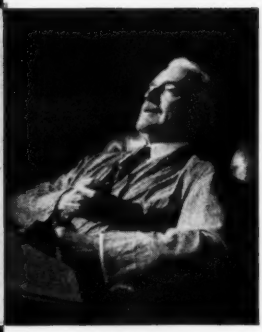
CLINICALLY TESTED AND CLINICALLY PROVED

The neurasthenic

The aged



The constitutionally delicate

The chronically fatigued

ESKAY'S THERANATES

THE FORMULA OF ESKAY'S NEURO PHOSPHATES, PLUS VITAMIN B1

THIS NEEDED EXTRA FACTOR

IN TREATING MUCOUS MEMBRANE INFECTION

ARGYROL offers three important properties which the physician seeks in treating mucous membrane infection. It is both *bacteriostatic* and *decongestive*. And, too, there is this EXTRA FACTOR in mucous membrane treatment with ARGYROL: *the physiologic stimulation of the tissue's own defense function.*

ARGYROL is truly the physiologic antiseptic. For in addition to being simultaneously contra-infective and contra-congestive, it is soothing to nerve ends and stimulating to glands. Its action is more than surface action: it is synergetic with the deep-seated tissue defense mechanism. ARGYROL provides combined physico-chemical and bacteriostatic properties that have proved of value to physicians for nearly a half-century.

In prescribing for patients, make sure that you specify Original Package ARGYROL.

ARGYROL — *THE PHYSIOLOGIC ANTISEPTIC WITH SYNERGETIC ACTION . . .*

* **Made only by the A. C. BARNES COMPANY, NEW BRUNSWICK, N. J.**

ARGYROL is a registered trademark, the property of A. C. Barnes Company

Speaking Frankly

Split

When I returned to my home town after taking a three-year residency in my specialty, I was chagrined to find that my colleagues continued to refer their cases out of town. However, I stuck closely to my job. After a year or two I was getting quite a few of their cases, but getting them directly and not through referral.

Finally, one of these men approached me with the information that "all" the doctors would send me their work if I'd split fees. I agreed; I just had to get volume.

A little later I had what I thought was a case of my own, but after the operation one of the G.P.'s said: "I talked those folks into getting the operation," and he asked for his share of the fee. Like a fool, I gave it to him. That sort of thing kept on until I found I was splitting with men who hadn't even seen the cases. To cap the climax, one man, on his return from some educational work in the East, found that I'd operated on one of his former patients and had the nerve to ask for his part of the fee! That was enough. From that time on I never split another fee.

M.D., Texas

Nailed

Medical men should circulate the names of fee-dodgers, with the aim of eliminating chiseling. Some time ago I delivered a woman of her second baby and got a hard luck story instead of a fee. Later I learned she hadn't paid another physician for her first delivery; but by that time I had delivered her of her third! Physicians who attended births Nos. 4 and 5 were not paid either—nor were the hospitals. I told the last physician of my experience, and he had his lawyer attach the husband's salary—which turned out to be $90 a week!

M.D., Massachusetts

Cliques

Some of the hospital cliques now discriminating against unaffiliated physician-veterans led medical officers a dog's life during the war. They went overseas as units, lugging their own nurses and administrative officers, and snatched every privilege right up to life from the fusty arms of the Army. They resented outsiders and used them for all the dirty and dangerous assignments; gave them inferior quarters; put them at the bottom of the list for promotions and leaves; and generally booted them around.

I saw them protect one of their favorite youngsters by hospitalizing him when he was ordered out with a division, while the doctor whom he was to replace froze his tail and dodged bullets waiting for the exchange. I saw a young "outside" doctor who had cracked up on an invasion ordered out to another

ERTRON

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SUPPLIED IN BOTTLES OF 50, 100 AND 500 CAPSULES

PARENTERAL FOR SUPPLEMENTARY INTRAMUSCULAR INJECTION

It is now known that Ertron is unique—differing clinically and chemically from all other drugs used as antiarthritic medication.

An extensive bibliography, based on 10 years of clinical research, affords ample evidence regarding the effectiveness of Ertron in arthritis.

It can now be stated, on the basis of recent laboratory research, that Ertron is chemically different.

Simply stated, Ertron is electrically activated vaporized ergosterol prepared by the Whittier Process.

Ertron contains a number of hitherto unrecognized factors which are members of the steroid group. The isolation and identification of these substances in pure chemical form further establishes the chemical as well as the therapeutic uniqueness of Ertron.

Each capsule of Ertron contains 5 mg. of activation-products having a potency of not less than 50,000 U.S.P. Units of Vitamin D.

To Ertronize-the arthritic patient, employ Ertron in adequate daily dosage over a sufficiently long period to produce beneficial results.

The usual procedure is to start with 2 or 3 capsules daily, increasing the dosage by 1 capsule a day every three days until 6 capsules a day are given. Maintain medication until maximum improvement occurs. A glass of milk, three times daily following medication, is advised.

Ethically promoted

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NUTRITION RESEARCH LABORATORIES • CHICAGO

dirty assignment, where he cracked up again. I saw many 40-year-old doctors and dentists mudding it out in beat-up, front-line dispensaries while affiliated lads in their upper 20's and lower 30's lived in steam-heated rooms during the European winter.

I charge that this is the record of the affiliated, closed general hospitals in this war. I charge that it stinks. Who agrees?

Ex-Medical Officer, New York

Retort

So Westchester County (N.Y.) doctors are "skeptical" of a plan to cut down the spread of airborne diseases by placing ultraviolet lamps in schools, churches, and movies, "because there are plenty of other places where persons can become infected"! That leaves many of us skeptical of the doctors' judgment. Any reduction at all of the hazard in places where people spend a great deal of time is justified. Scientists and physicians recognize the value and effectiveness of the ultraviolet lamp; many doctors have installed it in their offices for their own protection.

Dallons Laboratories
Los Angeles, Calif.

Stranded

Since Nov. 1, 1945, I have been trying to find a location. Apartments are not available and agents are demanding astronomical prices for private houses. The New York State Medical Society, which urged me to join the Army four years ago, now doesn't even care to know that I have survived twenty-nine months of front-line service.

My family has no place to live and I have no place to practice. B-

'anusol'

Hemorrhoidal Suppositories

fore joining the Army I had an eleven-room apartment, which has been occupied since by a physician —a younger man than I—who chose to stay home and rake in the money rather than risk his skin in the armed forces.

I have all the decorations, citations, battle stars, bronze arrows, and badges that my uniform can stand, a scar on my left thigh from a shell fragment, a hunk of steel in my lower lip, a bum left knee and right wrist. My family used part of my meager savings during my Army career. The professional perverts of democracy stayed home, ate and slept well, were not in danger of losing life or limb, raked in the dough, and now they laugh up their sleeves and call me a sucker. Perhaps if all of us veteran-physicians got together we could break up the large- and small-scale racketeering in the medical profession.

M.D., New York

Laurels

How many medical officers who served in World War II have received the nation's highest military award, the Congressional Medal of Honor?

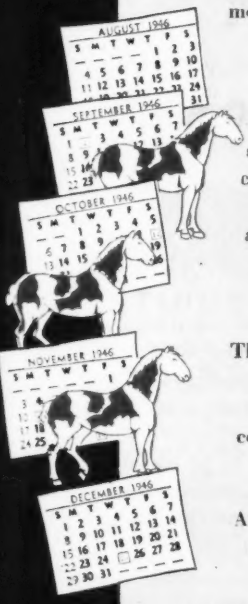
M.D., Utah

None. The six awards made to Army medical personnel went to enlisted corpsmen. The Navy says that when all the facts are in it is not improbable that the Medal of Honor will be awarded to several Navy medical officers.

About-face

The New Jersey M.D. who endorsed the Russian policy of permitting every woman one induced abortion says that he became familiar with this policy in 1936. He

Between the 40th and 140th day



ANTERON, Schering's anterior pituitary-like hormone with follicle-stimulating activity is obtained from the serum of pregnant mares between the fortieth and one hundred and fortieth day of gestation—when the hormone content is maximum. A potent preparation is thereby secured from which the gonadotrophic hormone can be economically extracted. A special refining process practically frees ANTERON of proteins and other allergens.

ANTERON

The combination of potency and safety in ANTERON is therefore of special importance when therapeutic effort in sterility, amenorrhea and certain functional uterine bleedings centers about inducing ovarian follicle stimulation and ovulation.

ANTERON is again available and may be obtained through your regular source of supply for ethical products.

TRADE-MARK ANTERON—REG. U. S. PAT. OFF.

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ANNOUNCES

A NEW TYPE OF CHEMOTHERAPEUTIC AGENT

Discoveries made in Eaton Laboratories[1] have resulted in the introduction of a new class of antibacterial agents—*the nitrofurans.* Over 200 of these have been studied *and give great promise of taking a place in chemotherapy with the sulfonamides and penicillin.*

One of these nitrofurans has proved to be especially effective. It has a wide antibacterial spectrum, including many *gram-negative* as well as *gram-positive* organisms. It is low in toxicity. This compound has been named FURACIN.

5-nitro 2-furaldehyde semicarbazone

During the past four years, Furacin has been widely used in experimental work. It has proved effective in many cases where sulfonamides and antibiotics have been unsuccessful. Clinical evaluation is continuing in many important medical centers.

This new antibacterial is first presented in the form of FURACIN SOLUBLE DRESSING.

first available in

FURACIN SOLUBLE DRESSING

for treatment of wound and surface infections

INDICATIONS

Infected surface wounds, or for the prevention of infection • infections of third and fourth degree burns • carbuncles and abscesses after surgical intervention • infected varicose ulcers • superficial ulcers of diabetics • secondary infections of eczemas • impetigo of infants and adults • treatment of skin-graft sites • osteomyelitis associated with compound fractures • secondary infections of dermatophytoses.

Furacin Soluble Dressing contains 0.2 per cent Furacin in a bland, water-soluble base, for topical application.

This preparation is bactericidal, both *in vitro* and *in vivo*[2] to many organisms characteristic of surface infections. Its antibacterial spectrum compares most favorably with those of the sulfonamides and penicillin. It is free of some of their disadvantages, being stable and relatively unaffected by body fluids.

Furacin Soluble Dressing liquefies at body temperature—is non-irritating—nontoxic—does not dry or cake—is readily removed with water or saline—has low index of sensitization—does not retard healing.

Available in 1 lb. jars for filling your prescriptions.

● **For literature on Furacin Soluble Dressing, write: The Medical Director, Eaton Laboratories, Inc., Norwich, N. Y.**

1. Dodd, M. C. and Stillman, W. B.: J. Pharmacol. & Exper. Therap. *82*:11, 1944.

2. Snyder, M. L., Kiehn, C. L., Christopherson, J. W.: Military Surgeon *97*:380, 1945.

should be informed that Soviet authorities revoked it in the same year. The pregnant Russian woman is no longer free to decide whether she'll carry to term.

M.D., New York

Runaround

Try getting supplies and equipment from the Smaller War Plants Corporation (not a man in it wearing a discharge button in his lapel)! They gave me the biggest runaround possible and were no help whatsoever.

Medical Officer, Missouri

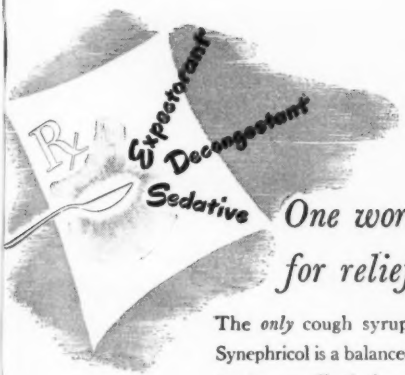
Exit

According to a news item in MEDICAL ECONOMICS, Dr. Lewis J. Moorman of Oklahoma wrote to Senator Wagner that "Under German social security the quality of medicine declined and the costs rose. Schiller had the courage to walk out." Schiller "walked out" in 1782, while the German social security program began in 1884. There seems to be a slight mix-up in centuries.

H. S. Unger, M.D.
Salamanca, N.Y.

Grasping

"Paul" is right. Most "overworked" physicians are extremely reluctant to refer any of their overflow to less busy men. A well established man in my section, when summoned by one of his older patients, first declined to make the visit and then, when pressed, consented to one evening call, with the proviso that if the patient didn't feel better the next day she'd have to go to the hospital. (It didn't matter that she wasn't a hospital case at all.) This doctor is the "boss" of his hospital; he can send in patients



One word prescription for relief of coughs

The *only* cough syrup containing Neo-Synephrine, Synephricol is a balanced formula of time-proved expectorants . . . effectively relieves bronchial congestion . . . 'loosens' the unproductive cough.

Synephricol

For Coughs Due to Colds

THERAPEUTIC APPRAISAL: Each 4 cc. teaspoonful contains:

Codeine* Phosphate	8.7 mg.
Neo-Synephrine Hydrochloride	5.0 mg.
Potassium Guaiacol Sulfonate	70.0 mg.
Ammonium Chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.0166 cc.
Alcohol	8%

INDICATED in coughs due to colds, especially dry unproductive coughs, and bronchial coughs.

AVERAGE ADULT DOSE: One to two teaspoonfuls every four hours.

SUPPLIED in bottles of one pint and one gallon.

*The codeine content of Synephricol is such as to allow the product to be classed as an exempt narcotic.

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DETROIT 31, MICHIGAN

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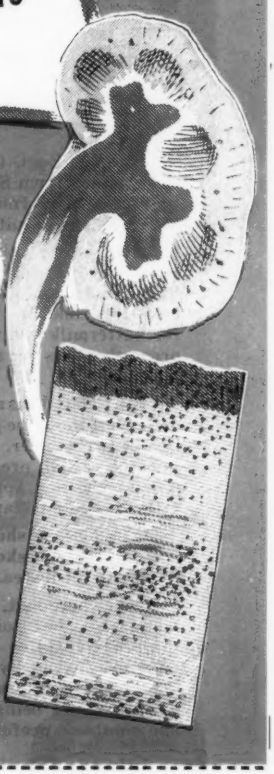
Trade-Marks *Neo-Synephrine* and *Synephricol*—Reg. U. S. Pat. Off.

It takes more time and effort to make anything *better.* Bayer Aspirin goes through seventy different tests and inspections to insure its quality, purity, uniformity, and fast disintegration.

BAYER *ASPIRIN*

RATIONALE:

Vitamin A Deficiency Often Occurs in Functional Renal Disorders Requiring Diuresis.



DIURETIC 401

- **produces satisfactory diuresis.**
- **provides generous daily dosage of vitamin A to help prevent epithelial metaplasia in renal pelvis, ureters, and bladder, and the infection which may occur in vitamin A deficiency.**

DIURETIC 401 Tablets contain: THEOBROMINE SOD SALICYLATE, Extract Buchu, Extract Uva Ursi, plus VITAMIN A

INDICATIONS: Functional renal disorders, renal edema requiring prolonged diuresis, particularly conditions associated with vitamin A deficiency.

Bottles of 100, 500, and 1,000 tablets.

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FREE! **FULL SIZE PACKAGE of *DIURETIC* 401 TABLETS**
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468 Dewitt Street, Buffalo 13, New York

Send my bottle of 100 Diuretic 401 tablets and literature to . . .

Dr.....

St. and No.....

City and State.....

with the most trivial complaints. But the younger men on the courtesy staff must be in desperate need of a bed before they can get one.

It seems to me that when a doctor becomes so busy that he can't see an ordinary case except in a hospital it's time for him to get an associate or to refer some of his cases to other men.

M.D., Oklahoma

Roots

The foundation of a specialty should be at least ten years of general practice. Without it, no specialist can do really good work.

M.D., South Dakota

Swapper

Will exchange: an Air Medal with one Oak Leaf Cluster, a Unit Presidential Citation, two campaign ribbons (each with a Battle Star), and a bottle of Scotch—all for a lease of office space anywhere in the U.S. (And hurry, please, before my family and I starve!)

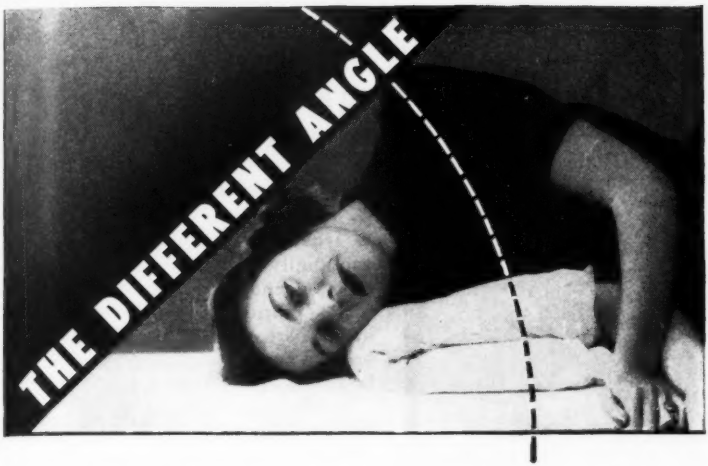
Ex-Medical Officer, Oklahoma

Fascism

The closed hospital staff is an example of medical fascism, pure and simple. If a man's record is clear, his license to practice should be enough to gain him staff membership, or at least the privilege of having his patients hospitalized. No G.P. with an inkling of common sense would attempt a major operation, yet many staff men are doing operations far beyond their ability.

Furthermore, the fact that a man does or does not belong to a moribund county medical society should have no bearing on his status in a hospital.

M.D., Maine



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POTENTIATED ANTIBACTERIAL POTENCY—urea-sulfanilamide mixture more effective than either drug used independently.[1] Not inhibited by pus.

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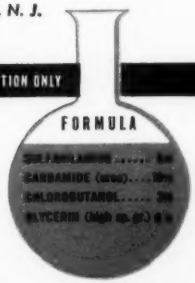

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2. *McClintock, L. A. and Goodale, R. H.: U. S. Naval Med. Bull., 41:1057, 1943.*
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4. *Strakosch, E. A. and Clark, W. G.: Minn. Med., 26:276, 1943.*

MEMO

to Doctors

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Shaving Lotion, Cologne, Hairdressing, 4 oz. $1.50; 8 oz. $2.50. Talc, 75¢, $1. Shaving Bowls, $1.50 and $2.50 . . . Gift Packages $2.25 to $10 Plus Tax. JOHN HUDSON MOORE, INC., 663 FIFTH AVENUE, NEW YORK 22.

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Sidelights

Every so often someone pops off with a statement to the effect that "the younger generation of doctors really *wants* Federal assistance; it's the older ones—the die-hards—who *object.*" Let those who make such generalities ponder the following statistic:

Only eight-tenths of 1 per cent of the country's demobilized doctors (the vast majority of whom are well under age 40) have thus far made any attempt to secure a G.I. loan for the purpose of establishing a civilian practice.

About 75 per cent have depended upon their own savings for working funds in getting started. Seven per cent say they have returned to establishments where no financial outlay is necessary. The other 17.2 per cent have borrowed from "private sources" (relatives, friends, physician-partners, and banks).

These figures, based on a survey being conducted by this publication, were compiled from replies received from some 2,000 demobilized men located in all parts of the country. (See also in this issue: "This is What Gripes Me . . . ")

One snag in certifying specialists today is the difficulty of balancing the applicant's basic knowledge with his clinical skill. Examinations sometimes overstress anatomy, physiology, and pathology. Familiarity with pathology, for example, is naturally expected of a specialist. Yet the busiest and best clinicians are the ones most often removed from the laboratory and immersed in the sick-room. These clinicians, while top-notch men, are not always conversant enough with the laboratory underpinnings of the specialty to satisfy an examiner who is himself a pathologist. Contrariwise, the M.D. fresh from graduate school may be sufficiently well versed in pathology to pass an examination in that subject but still have a long way to go as a clinician.

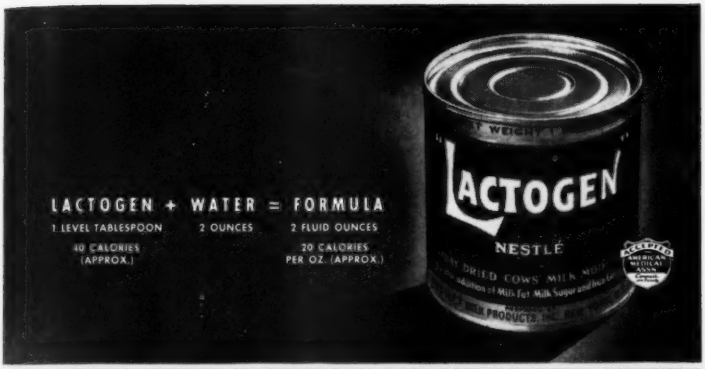
This overbalance will probably be corrected as the specialty boards feel their way through the problem in the future. If it is not, there is danger that their examinations may foster poor clinicians, more at home in the laboratory than at the bedside.

Unaccustomed as he is to public speaking, the busy M.D. is likely to cry, "Not me," when the medical society tries to draft him for a talk on sickness insurance. Too often, the lay organization asking for a speaker is not making the request in good faith, but wants a straw-man to knock down. This is especially true of certain welfare groups that are committed lock, stock, and barrel to Federal medicine. Consequently, when the practitioner who

appears before such a group criticizes the Wagner-Murray-Dingell bill or other efforts to bring utopia in our time, he is set back on his heels by a barrage of heckling. Not used to making snappy retorts in public, and unarmed with the health and economic statistics needed to cope with the heckling, the doctor sometimes beats a hasty platform retreat, vowing never again to debate on socialized medicine before any lay organization. This is an understandable resolve, but one which abandons the field completely to the proponents of compulsory sickness insurance and gives them grounds for saying that doctors have shied away from answering their arguments. What appears to be needed is a training course for M.D.'s that would enable them to venture on the public platform with the assurance that they knew all the answers. Giving physicians such training is certainly a legitimate and useful function of medical societies and one that deserves more consideration.

The Christian Science Monitor pointed out some time ago that Daniel J. Tobin, general president of the International Brotherhood of Teamsters, was opposed to sickness benefits. The conclusion was promptly reached in some quarters that Mr. Tobin, unlike most union leaders, was against Federal sickness insurance and that private medicine had at last found a friend in the camp of labor.

The assumption was ill-founded. The pragmatic Mr. Tobin objects to the payment of sickness benefits only *by unions*. Why? Because such benefits suggest "an enormous and ex-



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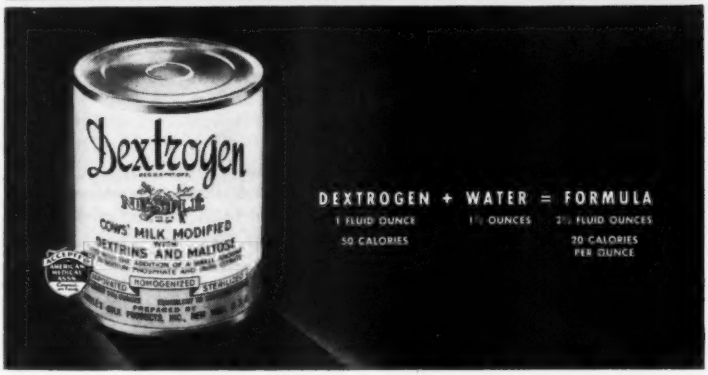

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pensive undertaking that might bankrupt any union in time of depression" and because "locals are often swindled by their members."

Sickness insurance is a wonderful thing, the nation's No. 1 Teamster implies, but only the Government has enough money and "a sufficient police force to properly and honestly enforce it." Let the unions avoid overloading themselves, he warns. "There are lean years ahead."

Reprints were made of a certain medical-journal editorial inveighing against Federal medicine. The reprints were distributed among the public and the profession, with the idea of getting as many people as possible to mail them to their Congressmen. Space was provided in which the sender could write his name and address.

What is the value of such stereotyped appeals to our legislators in Washington? Those responsible for the one described are enthusiastic. They point to the rather substantial number of people who actually signed the reprint and mailed it.

Congressmen feel otherwise. In recent conversation with several, this type of mass mailing was discussed. All turned thumbs down on it.

"The first question prompted by the receipt of a number of identical pieces of mail," said one, "is, 'How many clerks were paid to sign these things?' "

The individually written letter to your Congressmen is still the best approach. Composing such a communication takes effort. A man won't usually do it unless he has strong convictions on the subject. Legislators know this and are guided accordingly.

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1. Prompt reduction of blood pressure.
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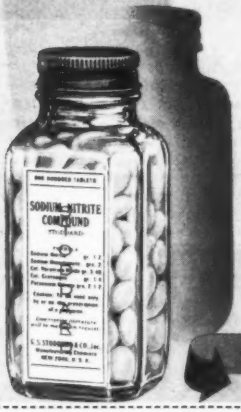

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Arterial hypertension is a dangerous condition — responsible for 15 percent of all deaths after fifty. (W. W. Taylor, Memphis Med. Journal, Aug. 1944).

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Tablets SODIUM NITRITE COMPOUND (Stoddard)

It not only aids in providing satisfactory reduction of blood pressure, with symptomatic relief of headache, tinnitus, vertigo, but the relief gained is considerably protracted.

The general action of Tablets Sodium Nitrite Compound (Stoddard) is that of a vasomotor dilator and cardiac tonic. It is indicated not only in essential hypertension but also in angina pectoris—in which its prolonged vasodilating action assists in the prevention and relief of anginal attacks.

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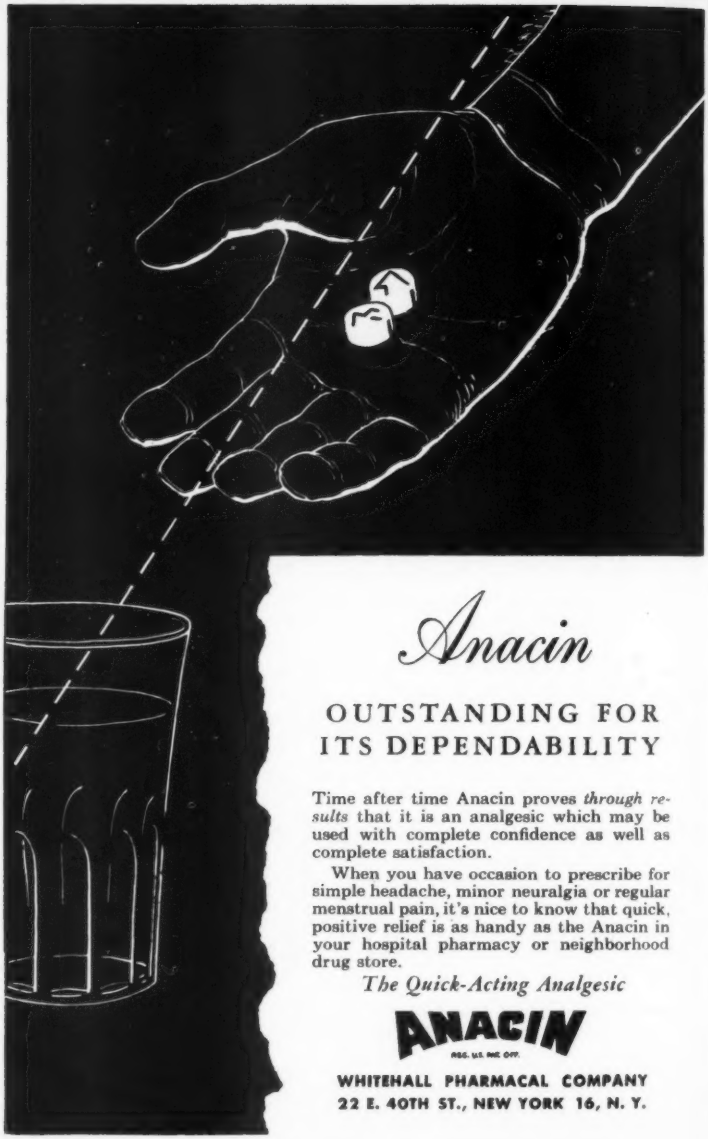

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OUTSTANDING FOR ITS DEPENDABILITY

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When you have occasion to prescribe for simple headache, minor neuralgia or regular menstrual pain, it's nice to know that quick, positive relief is as handy as the Anacin in your hospital pharmacy or neighborhood drug store.

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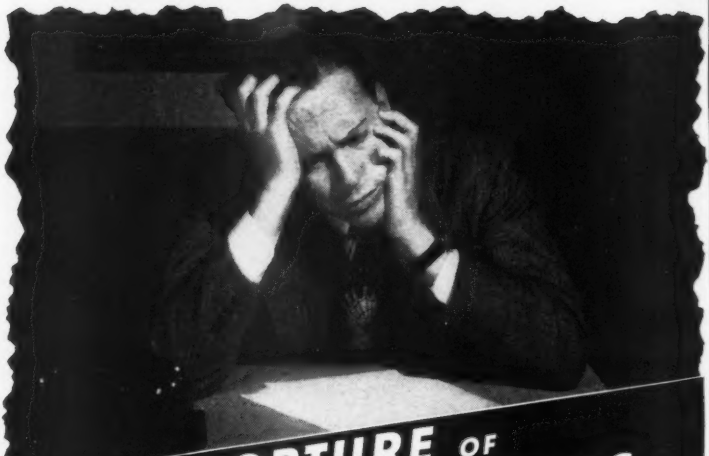

IN THE TORTURE OF PERIANAL ITCHING

Relentless, unnerving, anoperineal itching is among the most tormenting discomforts man is called upon to endure. The paroxysms of this frequently occurring syndrome appear without warning, day or night, and instantly rob the victim of further poise and productivity. Dependable, rapid relief is required to prevent serious emotional imbalance and traumatic lesions due to the irresistible desire to scratch. With Calmitol, such relief is promptly available. Calmitol quickly stops the annoying itching, and holds it in check for hours. Subsequent applications can readily be made at work, since the tube of Calmitol Ointment is easily carried in pocket or purse.

Calmitol stops itching by direct action upon cutaneous receptors and end-organs, minimizing transmission of offending sensory impulses. The ointment is bland and nonirritating, can safely be applied to any skin or mucous membrane surface. Active ingredients: camphorated chloral, menthol, and hyoscyamine oleate. Calmitol Liquid, prepared with an alcohol-chloroform-ether vehicle, should be used only on unbroken skin areas.

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Editorial

Test Case

A quiet revolution in the economics of private practice is now under way. The power behind it is a Government agency committed to the care of veterans by private physicians of their own choice. By last month the Veterans Administration had signed contracts with medical societies and society-sponsored organizations in the states of California, Kansas, Michigan, and New Jersey; other states were soon to be included also.

If the program is successful, millions of veterans, of whom many got free care in wards and clinics before the war will become private patients. Uncle Sam will pay doctors for attending those patients, using fee schedules that conform pretty closely with private fees in the several parts of the country.

This represents an immensely important test case for organized medicine. Proponents of compulsory sickness insurance are shaking their heads and saying that the medical-society-sponsored program won't work. They declare that doctors cannot organize and implement an administrative job of such size and complexity.

There would be no point in glossing over the fact that the project does face several hazards. One is the danger of non-participation. Some M.D.'s may be disinclined to treat veterans if it means conforming to a fee schedule and submitting bills on Government forms. If enough practitioners shun the program, the V.A. will be forced to hire physicians on a salary basis to furnish outpatient care. The result will be a strong boost for state medicine.

An opposite danger is also present: Those few M.D.'s who have not absorbed the profession's ethics along with its science may try to make a racket of veteran's care through such means as bill-padding, unnecessary calls, and mediocre treatment by mass-production methods.

To avert these hazards organized medicine will have to show intelligent and, above all, firm leadership. If dirty areas develop, it will have to do its own housecleaning. If non-participation threatens to sabotage the project, its dangers must be explained to the non-participants.

The private practitioners of the country now have a chance to cooperate in a huge Federal program on a voluntary, fee-for-service basis. Failure to cooperate would be an injustice to the veteran and a body blow to the profession itself in its fight against compulsion.

—H. SHERIDAN BAKETEL, M.D.

Reorganization of V.A. Medical Program Shows Good Results

Patients demonstrate new confidence; more physicians join staff

Hewing grimly to the task of reorganizing the Veterans Administration's medical and hospitalization program, Maj. Gen. Paul R. Hawley began to see heartening signs.

A daily average of thirty physicians and five dentists was being interviewed for positions in the new Department of Medicine and Surgery. This contrasted with a trickle of two or three a day before President Truman signed the legislation which authorized the department and withdrew medical personnel from Civil Service. Up to 150 letters were coming in daily to V.A. headquarters in Washington (see cut) from doctors and dentists (including an average of ten from overseas) requesting information or applying for positions in the administration's medical department.

General Hawley was particularly impressed by the fact that most applicants were high-caliber men. "If we can get a substantial group with such excellent qualifications and backgrounds in each V.A. hospital," he said, "our goal of a medical and dental service second to none in the world can be achieved."

General Hawley's cabinet of fourteen top-ranking medical and surgical men was busy appointing a nation-wide panel of specialists to oversee the job in the country's thirteen V.A. areas. Each specialist, on a $50-a-day fee basis, will make periodic surveys of the work in his field as carried on in the veterans' hospitals.

An unpleasant task remained: the weeding out of the administration's incompetents. In each hospital, the job was to be entrusted to specially constituted boards of physicians newly brought into V.A. service. The older men in the institutions would thus be spared the embarrassment of having to pass judgment on their colleagues. General Omar N. Bradley, Administrator of Veterans' Affairs, told newsmen he thought that few physicians would actually have to walk the plank. "I do not want to give the impression we are filled up with incompetent men; we are not. We have a lot of good doctors. We want to keep them and make their jobs more attractive for them."

Pork-barrel pressure on the V.A. hospital program continued, but General Hawley was given no reason to carry out the threat that he would quit the V.A. if he was prevented from placing veterans' hospitals where they would do most good. Congressmen were still insisting that he take over Army hospitals in their states and there were veiled threats that he would be ousted unless he played the patronage game, but he refused to budge.

The Washington Post, in an editorial captioned "Hospital Pork," come to the V.A.'s support. "Most ordinary people," it said, "would suppose that veterans' hospitals should be placed where they can do the most good. However, Senator Elbert Thomas and some other powerful Oklahomans seem to think that a veterans' hospital should be placed where it will do *them* the most good. . . More than half our veterans' hospitals are located in communities of 200,000 or less, and almost one-third in localities without a medical school or center. Senator Thomas would make this situation worse. . .

"What brought this simmering witch's brew to public attention was the question of what should be done with the 750-bed Glennan Army Hospital at Okmulgee, Okla., which the Army no longer needs. Senator Thomas asked the V.A. to take it over. General Bradley sent a special investigator to the spot, and is reported to be reluctant to have the V.A. operate the hospital . . .

"The reasons are simple. Okmulgee is a small city of 17,000 and offers only ordinary medical service; at Muskogee, thirty-five miles away—a city of 32,000—the V.A. is already operating a 418-bed general hospital; and in Oklahoma City, 100 miles away, a city of 204,000 and the home of the University of Oklahoma Medical School, plans exist to build a 1,000-bed neuropsychiatric hospital.

[*Continued on following page*]

"However, Senator Thomas thinks it would be nice for the V.A. to operate Okmulgee's Glennan Hospital as well. Says he: 'I have sent to General Bradley some data forwarded to me by the City of Okmulgee with the virtual ultimatum that if the V.A. does not take over the hospital I will ask why, when his organization comes before Senate committees for more money with which to expand its hospital program.'

"Of course, one couldn't call this blackmail. We will just say that the Senator is the victim of anachronistic thinking."

It appeared that the veterans themselves were satisfied with progress under Generals Bradley and Hawley. Wrote Dr. Howard A. Rusk in The New York Times:

"Less than a year ago I heard a seriously injured patient at Mitchel Field say, 'You're not going to send me to a veterans' hospital, are you Doctor?' His case was not an isolated one, but reflected the opinion most wounded men had of the V.A. medical service at that time.

"Yet only this week eighty paralyzed veterans at [the Army's] Halloran Hospital petitioned the Surgeon General to be transferred to the Veterans Hospital in the Bronx, not only because they wanted to be near home, but because they knew there was a new deal in veterans' medical care and they felt they would get the best possible medical treatment and rehabilitation training.

"The men directly responsible for the great strides that have been made, which have totally changed the attitude of disabled veterans, are Generals Bradley and Hawley."

—ARTHUR L. MYER

"WHAT YOU NEED IS REST."

Prepay Plans Mount in Number as Concept Gains Popularity

Advantages of a central authority to correlate program are cited

On Jan. 1, 1946, fifty-nine medical-society-sponsored prepayment plans were in operation in twenty-five states, and at least ten others were in process of development.* Though basically alike, these plans vary considerably in detail. Some are state-wide, some county-wide; others cover only a single community or metropolitan area. But all are voluntary and all provide free choice among participating physicians. Nearly all cover the entire family.

Most of the plans provide only in-hospital surgical and obstetrical benefits, with a nominal allowance for X-ray and anesthesia. Only a few furnish all medical and surgical services both in and out of the hospital.

In-hospital medical care is gaining favor with plan executives as a featured benefit. As a rule, a *per diem* rate is allowed for such care after the first few days. The benefit period ranges from a month to ten weeks. A waiting period of nine to twelve months on maternity cases and a year on tonsillectomies is generally required.

The most popular type of plan is a service-indemnity combination in which subscribers with incomes below a given ceiling get all the services contracted for and at the minimum fees shown in the fee schedule, while those with incomes above the ceiling may be charged an additional sum at the discretion of the doctor.

Other forms of prepayment vary all the way from the straight cash-indemnity arrangement offered by Ohio Medical Indemnity, Inc. to the contract in the State of Washington, which offers complete coverage with no income limit.

In many areas, cooperation with Blue Cross has been successfully effected. In such cases, the medical plan usually remains under medical control, retaining its own corporate identity, and the administrative work is handled by Blue Cross on a contract basis.

Numerous medical leaders have expressed the opinion that a major need in the overall program is for a central authority to coordinate the work of the increasingly numerous plans. The Advisory Committee on Prepayment Medical Care Plans of the AMA Council on Medical Serv-

*Plans were under way in Alabama, California, Colorado, Connecticut, Delaware, Iowa, Kansas, Lousiana, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Virginia, Washington, West Virginia, and Wisconsin. Plans were projected in Arizona, Florida, Illinois, Indiana, Kentucky, Maryland, Minnesota, New York, and Utah.

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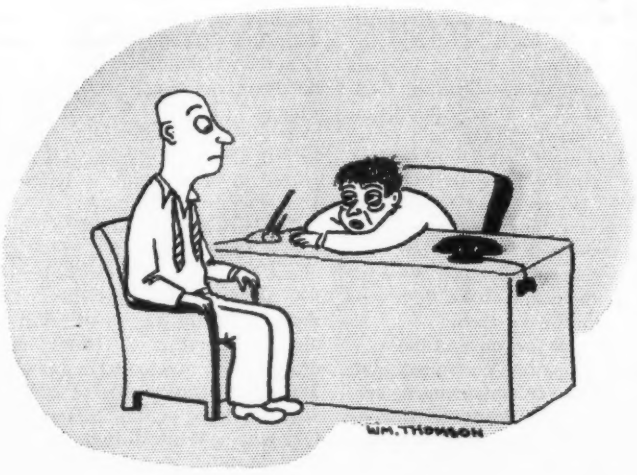

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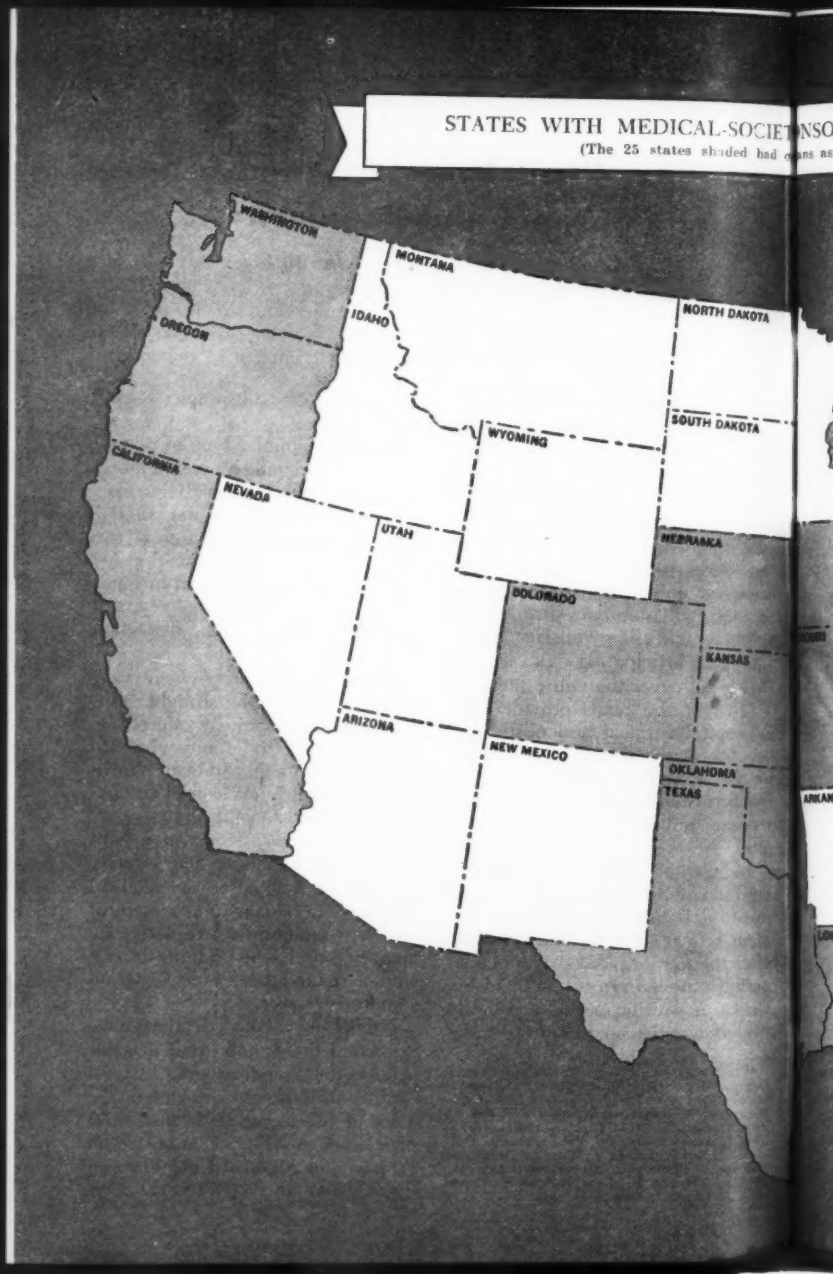
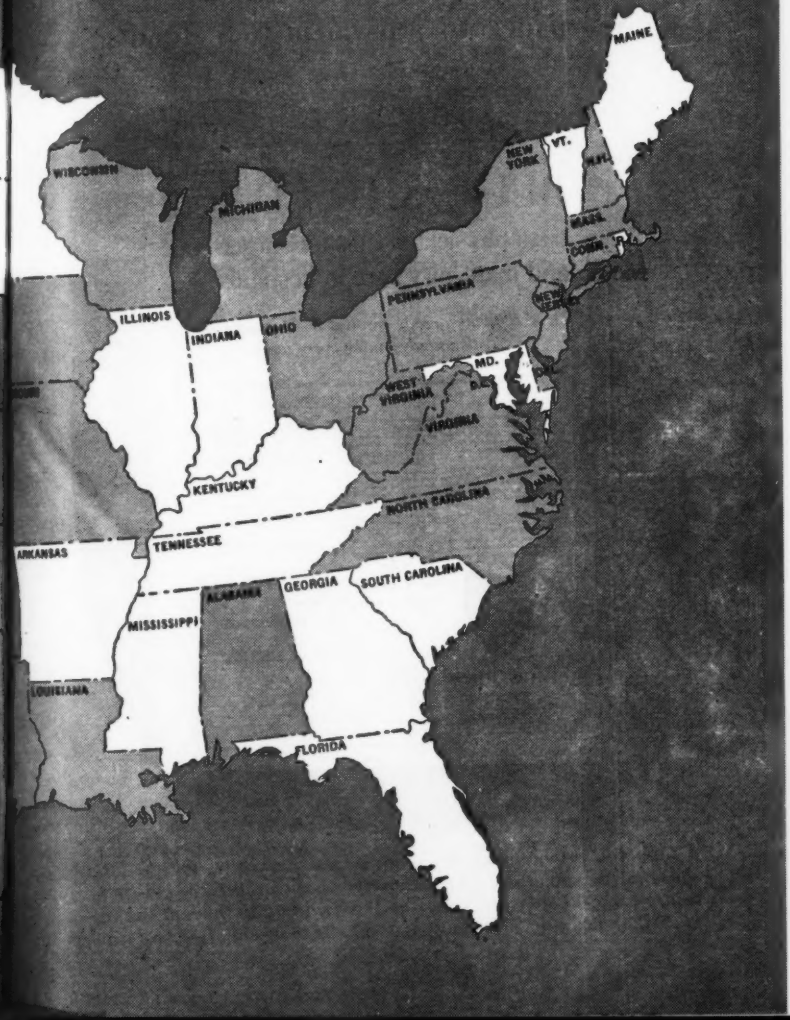
Numerous medical leaders have expressed the opinion that a major need in the overall program is for a central authority to coordinate the work of the increasingly numerous plans. The Advisory Committee on Prepayment Medical Care Plans of the AMA Council on Medical Serv-

*Plans were under way in Alabama, California, Colorado, Connecticut, Delaware, Iowa, Kansas, Lousiana, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Virginia, Washington, West Virginia, and Wisconsin. Plans were projected in Arizona, Florida, Illinois, Indiana, Kentucky, Maryland, Minnesota, New York, and Utah.


STATES WITH MEDICAL-SOCIET
(The 25 states shaded had
WASHINGTON
OREGON
CALIFORNIA
IDAHO
NEVADA
MONTANA
WYOMING
UTAH
ARIZONA
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS

NSORED PREPAYMENT PLANS

had plans as of March 1, 1946)



ice and Public Relations prepared a set of recommendations on this subject which was submitted last month to a joint meeting of the AMA Board of Trustees and the council. It called for nation-wide extension of the voluntary prepayment program, establishment of standards for plans, and an official emblem. —ALTON WELCH

Newspaper Advertisement Gets Results

BLUE SHIELD

pays physicians' bills for surgery and maternity care in hospitals

Over 200,000 already enrolled in Massachusetts ... thousands joining every week

Read how this non-profit plan—endorsed by your physician—saves you money when illness strikes

THE BLUE SHIELD SURGICAL PLAN protects you and your family against the cost of physicians' bills for operations and maternity care in the same manner Blue Cross pays hospital bills.

Sponsored by your family physicians and the Massachusetts Medical Society, Blue Shield is a low-cost, non-profit voluntary plan to enable you to provide in advance for costly surgical care.

Blue Shield is in its fourth successful year in Massachusetts—70,000 now are joining monthly.

Two out of every three hospital patients are admitted for operations or maternity care. Blue Shield spreads the risk over a large number of people—and through the magic of averages pays surgical fees few families could readily meet without hardship.

Over 4,000 Participating Physicians

You retain your valuable right to choose your own surgeon, physician or obstetrician if he is one of 4,000 now participating in the Plan. Without red tape or worry, Blue Shield pays your physician promptly.

If married, and your family income is less than $3,600 a year ($2,000 for a single person), you may be accepted as a member of the Blue Shield Plan for an payment in full for the operation. Thus, for only a few cents a day, people in this income group may receive the finest surgical service without worry about the cost.

If your income is more than the above amounts, Blue Shield pays its established fees toward the bill—you pay the balance, if any. Allowances are also made for X-ray and anesthesia.

Could you pay a big surgical bill tomorrow—without serious financial inconvenience?

HOW YOU JOIN

Per the present, Blue Shield membership is available only to groups of employees where five or more persons are employed.

If a Blue Shield group exists where you are employed, send the coupon and speak to the person in your company handling the group to find out when additional can be accepted.

If you work in a firm where there are five or more employees—and no group exists—Blue Shield will be glad to explain the benefits of your fellow employees now with you. Make your wishes known to your employer and send in the coupon.

2 out of 3 hospital patients require surgical or maternity care...

ARE YOU PROTECTED?

Blue Shield

A valuable addition to your Blue Cross Hospital protection.

Mail this coupon for information about the doctors' Plan today!

A topnotch promotional campaign is being credited with a large share in the growth of Massachusetts Medical Service, which recently had 200,000 subscribers and was adding to them at the rate of 20,000 a month. The newspaper ad above is one of several used.

P.G. and Residency Courses for Veteran and Civilian M.D.'s

G.I. financial assistance; current courses and residencies listed

If you as a veteran feel the need for advanced training, you can undertake a graduate course or a residency or both. Uncle Sam will help you out to the extent provided in the G.I. Bill of Rights. A medical officer veteran is entitled to as many months of educational benefits as he spent on active service between Sept. 16, 1940, and the "termination of the war," with a minimum of one year and a maximum of four. Time spent in ASTP or Navy college training courses is excluded in computing months of active service.

These educational benefits are twofold: (1) The Government will pay tuition fees and associated charges, such as laboratory fees, up to $500 a year. (2) The Government will, on request, provide an allowance of $90 a month if you have a dependent, or $65 a month if you have no dependents. The subsistence allowance, however, is not paid if you are earning (from practice or salary) an amount which is considered a reasonable income for a physician. For example, if you had a residency paying $150 a month with maintenance, it is unlikely that you would be considered eligible for a subsistence allowance since the income would probably be considered "reasonable recompense." On the other hand, if your residency paid only an honorarium of $100 a year or so, you would be eligible for a subsistence allowance. To draw any of these "educational benefits," you must enroll for the course or residency within four years of your demobilization.

Here are some questions which demobilized M.D.'s often ask about the educational provisions of the bill:

How about part-time courses?

Up to the maximum of four years, part-time courses may be prorated. Suppose you are entitled to a year of benefits and you take a course that takes three mornings a week. This is one-quarter time, since full-time would be six mornings plus six afternoons a week. If you take a year on that basis you would have exhausted only a quarter of a year

▶ This is one of a series of articles intended primarily to aid returning medical officers but likely to interest civilian physicians as well. The series has been incorporated in a manual, "Demobilized Doctor's Handbook," which is now being distributed by MEDICAL ECONOMICS.

and would still be entitled to 39 weeks of full-time study or its part-time equivalent.

How do I apply for these benefits?

Fill out V.A. Form 1950. You can get it by mail from the Veterans' Administration, by calling the nearest V.A. office, or, in most cases, from the hospital or medical school itself. Fill out the form, have it notarized, and turn it over to the school or hospital. They will do the rest.

What information is required on Form 1950?

This is a four-page folder with space for identifying data and it requires the following additional information: address of local draft board; Army or Navy serial number; dates of entry into and release from active service; ranks held; organizations in which you spent most of your military career; and a complete schedule of your educational background with dates of entering and leaving grammar school, high school, medical school, and graduate schools.

Do I apply for subsistence allowance on the same form?

Yes; on page 3 of Form 1950.

Is an officer on terminal leave eligible for these benefits?

Yes.

Is an interne or resident who receives maintenance plus a small cash stipend, also entitled to the subsistence allowance of a student?

In a test case in New York, the V.A. refused to grant an allowance because the interne was getting a small honorarium from the hospital. However, the V.A.'s Director of Vocational Rehabilitation and Education ruled as follows:

"It has been determined that where a person is pursuing on-the-job training and receiving compensation for productive labor as part of the course of training on the job, he may be paid a subsistence allowance provided the sum of the amount he receives from the employer and his subsistence allowance does not exceed what is considered to be the beginning salary or compensation for persons qualified to perform the functions of the position for which training is being pursued."

It was then decided that the stipend which this interne was receiving, plus the full subsistence allowance, "did not exceed a reasonable beginning salary for a physician." On the basis of this precedent, it would appear that allowances *are* payable to internes and residents if their salaries are nominal and if their hospitals are approved.

COURSES

Seeking a post-graduate course? Turn to the list of specialties beginning on the next page. Under each specialty are index numbers which will guide you to available post-graduate courses in the list of educational institution beginning on page 138.

Want a residency? Turn to the list of hospitals, arranged by states, which begins on page 143, and find the number range for any state desired (*e.g.*, Illinois, 200-244). Then turn to the list of specialties (page 56 ff.) and find any numbers within that range under your specialty. Then return to the list of hospitals and find the names and addresses of institutions whose numbers you have selected.

Listed herewith are (1) post-graduate courses scheduled for the first half of 1946; and (2) current residencies and assistant residen-

cies. While the listings have been based on data assembled by the Council on Medical Education and Hospitals, AMA, they do not necessarily imply approval by the specialty boards. Consequently it is suggested that you write to the board secretary of your specialty to determine the status of any institution in which you are interested.

POST-GRADUATE AND RESIDENCY INSTRUCTION CURRENTLY OFFERED BY MEDICAL SCHOOLS AND HOSPITALS

Index numbers refer to institutions listed on page 138 ff.

ALLERGY

Post-graduate courses: 3, 16, 17, 18, 31, 39, 52, 74.

ANATOMY

Post-graduate courses: 18, 19, 20, 27, 39, 59, 62, 75.

ANESTHESIOLOGY

Post-graduate courses: 17, 18, 20, 22, 40, 42, 57, 70.

Residencies: 102, 106, 130, 131, 153, 192, 215, 222, 225, 228, 229, 234, 253, 254, 262, 264, 271, 273, 317, 320, 321, 323, 368, 401, 454, 459, 471, 487, 496, 526, 531, 533, 538, 547, 550, 558, 559, 561, 563, 564, 594, 619, 644, 657, 663, 684, 686, 699, 703, 724, 752, 798, 799.

ARTHRITIS

Post-graduate courses: 3, 17, 31, 42.

BACTERIOLOGY

Post-graduate courses: 8, 17, 20, 62, 75.

BIOCHEMISTRY

Post-graduate courses: 19, 20, 62.

CARDIOLOGY

Post-graduate courses: 3, 15, 16, 19, 31, 36, 39, 40, 42, 52, 57, 59, 78.

Residencies: 252, 315, 320, 364, 694, 713, 724.

CHEMISTRY

Post-graduate courses: 20.

CHEST DISEASES

Post-graduate courses: 3, 11, 17, 19, 39, 50, 78.

Residencies (tuberculosis): 92, 94, 96, 102, 107, 108, 113, 118, 128, 132, 133, 144, 146, 150, 157, 165, 166, 182, 228, 231, 232, 240, 244, 245, 247, 253, 255, 263, 281, 282, 325, 340, 342, 347, 350, 351, 355, 356, 365, 378, 380, 381, 383, 384, 399, 400, 408, 414, 419, 426, 429, 455, 457, 470, 471, 475, 489, 490, 501, 508, 512, 515, 521, 524, 541, 547, 548, 571, 575, 577, 583, 592, 594, 596, 621, 625, 639, 651, 672, 682, 719, 725, 729, 738, 759, 779, 792, 803, 806.

COMMUNICABLE DISEASES

Residencies: 102, 119, 155, 207, 217, 297, 307, 321, 351, 365, 413, 433, 452, 490, 514, 568, 625, 697.

DERMATOLOGY, SYPHILOLOGY

Post-graduate courses: 15, 16, 17, 18, 19, 40, 42, 52, 75.

Residencies: 102, 130, 131, 178, 222, 228, 262, 273, 307, 320, 355, 360, 396, 398, 401, 422, 489, 496, 501, 526, 530, 548, 552, 555, 559, 602, 619, 625, 635, 663, 683, 686, 690, 702, 763.

DIABETES

Post-graduate courses: 16, 17, 19, 25, 31, 52.

ELECTROCARDIOGRAPHY

Post-graduate courses: 16, 17, 18, 31, 38, 39, 40, 42, 52, 64, 75.

ELECTROENCEPHALOGRAPHY

Post-graduate courses: 17, 58, 69.

ENDOCRINOLOGY

Post-graduate courses: 19, 31, 39, 42, 52, 59, 75.

ENDOSCOPY

Post-graduate courses: 18.

FRACTURES

Post-graduate courses: 31, 39.

Residencies: 144, 207, 360, 561, 724.

GASTROENTEROLOGY

Post-graduate courses: 3, 15, 16, 17, 18, 19, 31, 39, 40, 42, 59, 64, 75.

HEMATOLOGY

Post-graduate courses: 3, 16, 19, 31, 42, 52, 75.

INDUSTRIAL MEDICINE

Post-graduate courses: 17, 31, 69, 75.

GENERAL MEDICINE

Post-graduate courses: 15, 55, 46, 10, 22, 21, 57, 18, 58, 27, 51, 53, 33, 52, 59, 75, 60, 50, 19, 31, 16, 17, 39, 40, 42, 8, 20, 43, 76, 64, 3, 65, 66, 68, 7, 70, 49, 71, 35, 72, 73, 34.

Residencies: 81, 82, 85, 89, 93, 99, 102, 106, 111, 115, 118, 119, 120, 125, 126, 128, 130, 131, 132, 133, 142, 144, 160, 162, 170, 174, 175, 176, 177, 178, 185, 187, 188, 191, 192, 194, 207, 214, 215, 216, 218, 219, 220, 221, 222, 224, 225, 228, 229, 234, 235, 242, 252, 253, 262, 264, 271, 273, 276, 282, 285, 286, 287, 289, 290, 291, 292, 293, 294, 295, 296, 298, 299, 300, 306, 307, 316, 317, 320, 321, 324, 353, 355,

[Continued on page 131]

HOW INCOME TAXES REDUCE INTEREST ON YOUR INVESTMENTS

Not all buyers of real estate and securities appreciate the extent to which the return on such investments is reduced by the Federal income tax at 1946 rates. This table shows the *net* return after tax on investment income at several *gross* rates of interest. Example: If your taxable income is $10,000, the next $2,000 added to your income is taxed at the rate of 36.1 per cent. If this $2,000 represents a 4 per cent return on an outside investment, the actual net return will be reduced by taxes to 2.6 per cent.

Net Taxable Earned Income	Additional Investment Income	1946 Normal and Surtax on Added Income In Column 2	Gross Interest Return		
			5%	4%	3%
			Net Return After Federal Tax		
$ 5,000	$ 1,000	24.7%	3.8%	3.0%	2.3%
10,000	2,000	36.1	3.2	2.6	1.9
14,000	2,000	44.7	2.8	2.2	1.7
18,000	2,000	50.4	2.5	2.0	1.5
22,000	4,000	56.1	2.2	1.8	1.3
32,000	6,000	61.8	1.9	1.5	1.2
50,000	10,000	71.3	1.4	1.2	.9

Getting the Most Out of Your Savings

A neat trick in the face of burgeoning taxes and diminishing interest rates

Higher living standards, increased income taxes, lower investment yields, and substantial Federal estate taxes compel us to spend more and save less. Financial loss is thus inevitable. The trick is to minimize it. But how?

As recently as 1930, U.S. Government bonds were yielding better than 4 per cent; savings banks were paying depositors 4-4½ per cent interest; long-term, high-grade corporate bonds were returning 5 per cent; and on good quality stocks we could get 6 per cent. Income taxes were comparatively low, so that for the man in the better-income bracket, the problem of estate accumulation was not serious. What's more, much of one's accumulation could be passed on without too serious a drain from Federal estate taxes.

Now witness today's conditions. U.S. Government bonds are yielding 2½ per cent, savings banks pay 1½-2 per cent, high grade corporate issues yield about 2¾ per cent, and good stocks pay no more than about 4½ per cent.

No informed individual believes that low interest rates are only temporary. With a possible $300 billion Federal debt to carry, the Government is hardly likely to let interest rates rise.

Several of the larger life insurance companies have already changed to a lower interest reserve basis. That others will soon follow suit is ample indication of what is anticipated, interest-earnings-wise, in the future. The $45 billion life insurance institution is adjusting itself to what it expects to earn in the years to come.

Future Federal budgets are expected to be $20-25 billion annually. Of this amount, approximately $6 billion will represent the annual interest charge on our bonded debt. Amortization will require additional billions. Under the circumstances, no substantial drop in income taxes is to be expected for a long time.

Because of continued low interest rates, twice as much principal will be needed in the future as was needed in the past to produce a given amount of income. Along with continued high income taxes, this can mean only one thing. We will all have less to save and accumulate. To top it off, Federal estate taxes will continue to take a larger share of our estates—the net result being less for our heirs.

Not long ago when it was possible to secure a return of 5-6 per cent on investments and when income taxes were comparatively low, annual savings of $1,996-$1,720 (at

the interest rates cited) would accumulate an estate of $100,000 in 25 years. This provided an annual income of $5,000-$6,000. Today, allowing a safe return of 3 per cent, we need a principal sum of $200,000 to produce an equivalent income. Assuming the same period of accumulation, this means saving $5,326 a year.

It is not what gross rate of return you get on your funds that determines your financial position later, but what net amount you are able to accumulate. Often overlooked is the fact that investment income is taxable in the top surtax brackets. The accompanying table illustrates what you must gross to produce a desired net.

Low investment yields and high income taxes are serious enough in themselves, but there is yet another problem to consider. In 1930 an estate of $200,000 required a Federal estate tax of only $1,500. Today, the same size estate owes the Government twenty-two times as much, or $33,000. Not only does this mean a reduction in the size of the estate, but in the beneficiaries' income as well.

Can a solution be found to these problems? In part, yes.

One fundamental principle to observe is the exclusion of values from your taxable estate. Property and investments which are transferred either by outright gift or by establishment of an irrevocable living trust are removed from the top Federal estate tax brackets. What is more, the subsequent income from these transfers becomes taxable to other members of your family, who no doubt will be subject to much lower tax rates. Under a properly drawn trust, when final distribution of the principal is made, further savings are assured in that there will be no additional estate taxes nor administrative fees.

It is obviously unwise for a man to make investments that consistently produce income beyond his needs, when, because of high taxes, so little of this income can be retained. A way must be found to defer income until later, when income taxes will probably be lower and personal earnings may not be so important a factor in tax calculations.

In planning for the future of his family, a physician faces a far graver problem than the man who owns a commercial business. No matter what may be his skill and professional standing, and no matter how much good will he has built up, all that remains at his death or retirement are his professional equipment and accounts receivable. Security for his family must come from capital or life insurance acquired during his active years.

Dr. X is a well-known cardiologist in his forties. For several years his practice has netted him $24,000 annually before income taxes. Through prudent conservation of an inheritance and by wise investment of a portion of his annual income, he has accumulated an estate of $200,000 composed of the following assets:

Real estate	$ 30,000
Life insurance ...	50,000
Securities	120,000

The net income from this capital has averaged $6,000 annually. His total net, before taxes, averages $30,000. Roughly $13,000 of this net, however, has been paid out annually in income taxes.

His family consists of his wife, two married daughters, and a son discharged from the service and reentering college. He has accustomed them to a standard of living in keeping with his means and, until recent years, has been able to put aside a substantial portion of his income for investment. His will, drawn several years ago, leaves his entire estate to his wife, expressing confidence that she will provide adequately for their children. His complacency has been disturbed of late, however, by a recognition of two problems:

1. Each year he has been able to set aside less of his income for investment. Rising living costs and rising tax rates have consumed more and more of his funds.

2. At his death, last illness expenses, administrative costs and estate and inheritance taxes will reduce the estate available to his wife by about $40,000. In addition, if Mrs. X survives him by five years, at *her* death the estate will be subject to a second set of administrative costs and taxes to the extent of about $25,000. This means a total reduction of $65,000 before the estate will have passed to their children.

Analyzing his income problem first, Dr. X discovers that many of the means by which income taxes may be reduced are not available to a physician. A man who owns a commercial business can incorporate it, transfer shares of stock to his wife, and have the divided income from those shares taxed in low brackets as income to her rather than in his own higher tax brackets. Income from personal services,

Handitip

Biological Jug

The familiar, gallon-size thermos jug can be used as a storage receptacle for biologicals. In its center place a capped olive bottle filled with ice cubes and around it place your packages. —M.D., UTAH

however, cannot be so divided. "Earned income is taxed to him who earns it and unearned (that is, the fruit of ownership) to him who owns the tree"—this well settled income tax principle leads Dr. X to a practical solution of his problem.

Mrs. X has had no taxable income. By transferring securities outright to her, therefore, it will be possible to have the income from them taxed to her at a low rate rather than to her husband at his much higher rate (well above 50 per cent). Dr. X has never used any part of his $30,000 lifetime gift tax exemption. He decides to transfer $60,000 worth of securities to Mrs. X, of which only $30,000 worth will be subject to a gift tax of $2,250. He can make the gift either outright or in trust; but since he chooses an outright gift, he may exclude an additional $3,000 from gift tax. (Under the Federal gift tax regulations, it is possible to transfer outright $3,000 annually to each of as many persons as one chooses without paying a gift tax thereon.)

This transfer will give Mrs. X income of $2,400 a year. It will be subject to a tax of roughly $350 rather than to a tax of some $1,200 as part of her husband's income. Mrs. X will accumulate this income and invest it under her husband's direction. Over a period of ten years, the program will enable them to increase her capital by $20,000. If the income were taxable to Dr. X during the ten-year period, the increase in capital would be about $8,000 less. Furthermore, Dr. X can, in future years, transfer outright to Mrs. X $3,000 annually—*free from gift tax*.

If Dr. X lives to complete his program, at the end of ten years Mrs. X will have an estate of $110,000. Since his capital has been reduced by the $60,000 gift to his wife, and since no further accumulations have been made in his name, his estate will be worth about $140,000. The estate tax on it, at present rates, would be about $15,000, instead of the $33,000 which would have been due had he not made the gift. At his wife's death, the tax on her estate will be, at present rates, about $7,000. This makes a total tax of $22,000 on the combined estates.

Reducing the tax on their combined income and transferring $3,000 annually to Mrs. X over a ten-year period will have increased the total of their two estates to $250,000. If it were taxed as one estate, the levy would be almost $66,000.

One further step is necessary to make this program completely effective: Dr. X and his wife sign parallel wills by which each leaves the other a life interest in the income from their property while the principal is to be held in trust for their children. This prevents the estate of either from being added to the estate of the survivor, and thus avoids the possibility of a second tax being levied against the estate of either when it ultimately passes to their children. As a result, there is a total saving in estate taxes of approximately $30,000. There

will also be a substantial incidental saving in administrative expenses since the estate of the first of them to die will pass to their children under the original will rather than under the will of the survivor.

—WILLIAM P. PARR, CLU

Rare Drugs, Rare Job

Martin H. Heeren

If you happen to own a little diiodehexamethyldiaminoisopropanol — or, for that matter, any other rare chemical—Dr. (Ph.D.) Martin H. Heeren would like to know about it. Locating such rarities is Dr. Heeren's job. He's director of the National Registry of Rare Chemicals, a non-profit information bureau set up four years ago by the Armour Research Foundation in Chicago.

The registry was Heeren's idea. Needing a certain compound to complete an experiment, he sought vainly for it in supply house catalogues, wrote letter after letter to company after company before he could obtain a small quantity. Were other chemists having similar troubles? Were other experiments being delayed—or abandoned—for similar reasons? Why not a central source of information to act as a clearing house?

With the cooperation of various manufacturing chemists, Heeren began to compile a card index of non-catalogued items. Soon the Armour Foundation, with which he was associated, asked him to make it a full-time task.

Today, the index is a priceless source of information. It contains the names of some 7,000 little-known chemicals, tells who has how much of each. Letters arrive daily from pharmaceutical houses, medical men, hospitals, Government agencies, and chemists the country over seeking to find the source of a few grams of this or that. A large majority of the inquiries can be answered immediately. The others require detective work on Heeren's part; and though his sleuthing is generally successful, there are always a few items which he isn't able to locate. But he never gives up the search—for no inquiry is ever closed until the wanted chemical is found.

In no wise is the registry a brokerage house; its services are rendered without charge to either buyer or seller. On occasion, when one party or the other wishes to remain anonymous, the registry acts as a go-between in the actual exchange of goods and money. For this and other reasons of secrecy, its records are highly confidential.

—WILLIAM H. EGAN

Medical Education's Major Task Is Teaching the Teachers

Lazy, self-satisfied faculties are a liability to the profession

I am profoundly concerned for the future of medical education. I am concerned for the future of the medical schools in any country where good medical care does not reach large portions of the population.

In the United States, our younger graduates are not taking the places of the older doctors in rural areas. Doctors are being criticized because the cost of their services is beyond the reach of a large portion of the public. The distribution of medical care has become seriously defective. Yet most medical schools have ignored, evaded, or denied their obligation to inform their students on these most widely discussed and heatedly argued subjects confronting the profession.

In some schools decorous inquiries were made as to the political affiliations of those who were prepared to lecture on medical economics, but not as to whether they had facts to discuss. In at least one school discouragement was offered in the more explicit declaration that it is not the proper function of the medical school to present lectures to students on such a subject—an opinion that left some at least of the younger realists muttering.

SPECIALISTS AND G.P.'S

Our medical schools must train their students to practice in well coordinated groups using the facilities of hospitals not merely for early diagnosis and for cases of acute and complicated disease but also for outpatient supervision, for preventive and protective medicine, for convalescence, and for chronic disease. This does not mean either the end of the general practitioner or that a good hospital is his enemy. It is his ally.

If it is the belief of most schools that they should train students to be general practitioners, I agree. A good general training is the right goal. But it would be better, first, if we accepted fully Lester Evans' thesis that general practice should be considered and dealt with as a specialty, and, second, if the energies of the school were focused on

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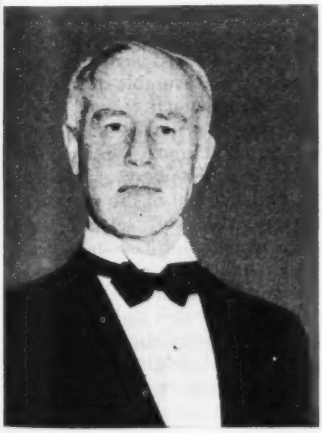
▶ Dr. Alan Gregg, director of the Rockefeller Foundation's division of medical sciences, had important and provocative things to say at a symposium on "The State of the Nation's Health," which was sponsored recently by New York University. This article is a condensation of his remarks.

he kind of teaching that would fit tudents to enter eventually into ny of the specialties. Such a dec- ıration of policy would provide a ational basis for insisting on a road training preparatory to spe- ialization. It would acknowledge he importance of the general prac- itioner's task. And it would place a eeded emphasis upon the actual onditions under which a specialist nust learn his role as a member of a team in providing the public with good medical care.

FUNDS INADEQUATE

Another thing: I do not believe here is sufficient awareness of how harp are the contrasts between academic salaries and the incomes of physicians in private practice. If you allow a professor of medicine or surgery to have out of, say, fifty- four hours a week only six for pri- vate consultation work he will be able to double his academic salary. For eight-ninths of his time de- voted to his medical school work he may receive from the university an amount equal to what the public will pay for one-ninth—and not in exorbitant fees either.



Dr. Alan Gregg

A system such as this is unwise. It results in a curious assemblage of teachers, a mixture of extraordinarily fine men of the greatest possible value who do not care to leave teaching and research and others who do not dare to.

The costs of medical education are borne by tuition, by endowment income, and by those rich whose large doctors' bills support clinical part-time professors who contribute substantially and with little or no recompense to the teaching of students. The relative proportions of these three sources of medical school income vary widely in different parts of the world. In our endowed American schools, especially those with full-time teachers, the role of endowment income is extremely important. Yet from 1929 to 1934 the endowed medical schools lost about a third of their endowment income. They held on courageously for six years after that but the teaching expenses of a medical school cannot be discharged by small grants-in-aid for selected bits of research.

The war increased the student numbers and provided a transitory and fictitious prosperity. But until the endowment income of our medical schools is increased by fifty to seventy-five per cent we shall not be able to train doctors to the standard of 1928 nor as you will wish they had been trained. This warning I have taken the trouble to confirm by consulting some twenty-five deans. [*Continued on next page*]

—Handitip—

Extra Car Keys

Duplicate ignition keys are of little use if they are in another suit when you've locked the regular set of keys in the car. For that reason, I've wrapped a spare set in oiled silk and taped them to an inconspicuous part of the underside of the car body. —M.D., MICHIGAN

I cannot hear talk about the immense progress made by medicine as shown by the sulfa drugs, penicillin, DDT, and plasma in the war without pointing out that these wonderful results depended on the training and teamwork of the doctors using those substances. Don't forget that in the hands of doctors not well trained the results of these same substances were nil—or worse. That is the essence of modern medicine—adequate training in the right use of frighteningly effective agents, such as X-ray, radium, insulin, electric shock, powerful chemicals, and psychological therapy.

TEACH THE TEACHERS

Highly technical and highly dangerous as are many of the procedures of modern medicine, the school has other functions besides that of making a safe practitioner. It has the task of leadership. It has often been assumed that the major task of medical education is to teach medical students. That is false. The major task of medical education is to teach the faculty. I have seen efforts to improve medical education in many parts of the world. Never have I seen the apathy or the recalcitrance of the students as the cause of failure. Nearly always it was the administrators'—or sometimes the teachers'—anxiety at the threat to their status, their laziness, or self-satisfaction which was to blame. The teacher teaches by his example as well as by what he considers his teaching.

THE DOCTOR'S ROLE

The way a doctor thinks about his role, about his patient, about human life, is more important than just the facts he has learned or the skill acquired. In nearly every serious illness, the doctor often has the obligation to give advice that is based not on science but on human values, on wise appreciation of the limitations and the potentialities of human life. The Faculty of Medicine at New York University realized these truths when it proposed a Department of the Humanities in Relation to Medicine. The age-old task of the physician is rooted in humanism; his methods must be objective but his purpose must be sympathetic, the means scientific, the end essentially kindly.

The past hundred years have witnessed an immeasurable quickening of the social contacts of man, a shift to a society acutely dependent upon the internal harmony of its parts. The greatest discovery of the century has been that of the process of discovery itself—of scientific research—which the last ten years have brought within the comprehension of the whole world. We rub the lamp of research and in a towering cloud appears the genii to do our frightened bidding. Our task now is as heroic as it is urgent: to hammer out a moral or ethical code that will fit the realities of modern existence. —ALAN GREGG, M.D.

The 'Live Memo' Keeps Your Records Up-to-Date

It's a special blessing for the man without a secretary

"I'm just starting out in practice and I'll have to do without a secretary for a while. Can you suggest a simple but foolproof method of keeping tabs on appointments, charges, and collections while absent from the office?"

One answer to that question, which many a vexed young physician has asked, is the "live memo"—a device that combines simplicity with efficiency and constitutes one of the essentials of good record-keeping.

A physician must know whom he is to see each day, and where. He must know later whether he saw them by appointment or unexpectedly. Often he has to know when and where they are to be seen again. Why he saw them is important (they may ask him some day when disputing a bill). In addition, it is necessary to know how much the fee was in each case and whether it was paid in full or in part or not at all.

Keeping tabs from day to day on

these facts may seem complicated; but the only equipment you need to make it simple is a pocket notebook of the live-memo variety and a small storage box.

The memo book can be purchased at any stationery shop. It consists of a leather binder with pad inside. A handy kind has a 6¾" x 3" size page perforated along the binding and across its face. The perforations divide each page into sections, any one of which can be torn out without disturbing the others. When one pad is used up, another can be inserted in the binder.

Each day's appointments are listed ahead of time in order—one to each detachable section of a page. Unexpected calls are added as they come in. Every visit is identified as either "home" or "office." At the time the call is made, other pertinent facts are jotted on the slip. A few words will usually identify the ailment and treatment given. "Rx," followed by abbreviated prescription data, may be added. Fees are easily noted.

If a subsequent call is indicated, a record of when and where it is to take place is entered several pages ahead. An exact spot doesn't have to be chosen since each section of each page remains intact until it is torn out.

A good idea of what the page sections look like when filled out can be gathered from the illustration. The slips represent two home calls made on the same patient two days apart.

It is important to understand that each slip identifies only one call and bears a financial record of that call only. In other words, charges are not entered cumulatively.

At the time of the March 11 call on Smith (see cut), no payment was made; hence, the notation, "$3 charge." Brown, on the other hand, paid for his call, so an entry was made accordingly.

Now, about that storage box. It should be of a size that will occupy little space on top of a desk or in a drawer. A cigar-box will do nicely.

Once a day, when convenient, completed slips may be torn out of the memo pad and slipped into the box. Reminders of future calls are left in the pad.

The storage box swallows a week's accumulation of memoranda. Its contents may be disposed of at the end of this period in one of two ways:

¶ By sorting the slips into 9" x 12" manila envelopes (each to be filed alphabetically according to the name of the patient it bears, and to contain such case history data as are necessary); or

¶ By transcribing the information on the slips to such financial- and history-record cards as may already be in use.

Practitioners who manage without a secretary and have tried this live-memo system declare it ideal. Bookkeeping detail is systematized, and an instantaneous reminder of where to go next is always at hand. Even the physician who has an office aide will find the idea advantageous since it gives her more time to do other chores. If there is no time in any given week to file the slips, there is no loss of efficiency. It may be done later. The arrangement differs radically from those that tend to go to pieces if not attended to at specific intervals.

—A. S. CONRAD

What Interest You May Deduct on Your Income Tax Return

Also, what interest the Government says you may not *deduct*

Most interest payments made during a given year may be deducted from gross income in computing your Federal income tax for that year.

Interest paid as part of professional operating expenses ranks, of course, as a "cost of doing business" and is deductible as such. Interest paid in many personal transactions is also deductible. Specifically, you may deduct all interest you were liable for—and actually paid—on:

Loans. It is immaterial whether the money was borrowed from a bank, finance company, or individual.

Mortgages. This includes interest on mortgages on real estate now owned by you and on mortgages on real estate formerly owned by you if, in the tax year, you were still liable on the mortgage bond and had to pay the interest. If you are personally liable on the mortgage of a corporation, you may deduct the interest you paid on that, too.

Installment purchases. If you bought an automobile, a household appliance, furniture, or anything else on a deferred payment basis, you may deduct interest charges included as part of your installment payments. To make such a deduction allowable, however, the interest part of the payments must be segregated from principal in your contract with the seller or in the actual payments. Deferred payment deals are variously set up as personal loans, conditional sales, bailment leases, chattel mortgages, or simple installment payments on account of unpaid balance. Unless the interest element can be definitely identified and separated, it cannot be deducted.

Notes. This includes interest on your own notes and on the notes of others for which you are legally liable, if you actually paid it. A common practice with banks and other lenders is to discount notes—that is, to deduct interest in advance. Thus, if you discounted a note for $1,000 at 6 per cent, you received $940. Only when you repay the $1,000 will you really pay the $60 interest; you may not deduct it *until* you pay it.

Life insurance loans. Interest on such loans is deductible only if paid in cash. If the interest is added to the amount of the loan, it is *not* deductible.

Ordinary debts. Interest paid on an ordinary debt, even when the debt is not in writing, is deductible. In some states, judgments and open accounts bear interest at a specified

legal rate; such interest is deductible when actually paid.

Family loans. Interest paid on loans from your wife or other members of your family is deductible if you can show the debt is bona fide.

Delinquent taxes. If the Government rules that you have not paid your full tax, you will be charged interest on the deficiency. You may deduct the interest from your gross income, though you cannot deduct the amount of the tax deficiency itself. A tax *penalty* is not deductible.

You may *not* deduct interest on: *Notes, mortgages, and obligations of others* for which you had no legal liability. For example, if you paid your son's mortgage interest to save him from foreclosure, you may not deduct it.

Margin account with your broker unless you paid it in cash or unless the broker collected dividends, interest, and proceeds of sales of securities out of which he took the interest due him.

Giving a note for interest or giving a note for the full amount of the debt plus interest is not considered payment, and deduction for interest in such transactions is ordinarily not permissible. —HUGH BRUCE

"WHAT DID DADDY MEAN—'THAT SHOWS YOU WHAT A FEW DRINKS WILL DO'?"

A Private Hospital of Less Than Forty Beds Is a Poor Risk

It can't provide adequate facilities without going into the red

What kind of economic future does the small, privately owned hospital offer? Physicians planning to associate with such a venture would do well to consider that question.

For one thing, a privately owned hospital begins as a poor investment because it must offer rates comparable to those of hospitals that are built and supported either by tax subsidies or by endowments and that are in most cases tax-exempt. Unfortunately, taxes, interest on invested capital, and amortization often represent a continuous charge against operating income of about one dollar per bed per day. This means that the privately owned hospital, to remain solvent, must collect an average of $1 per day more than is collected by the subsidized or endowed hospital.

Even where competition is not a factor, in towns so remote from existing hospitals that transporting patients to them is impracticable, the small, privately owned hospital is an economic risk. The cost of operating a hospital depends mainly on the number of its beds, regardless of whether they are occupied, while the income depends upon the number occupied and the ability of the occupants to pay normal rates for hospital care. Generally, at least 70 per cent of a hospital's beds must be continuously occupied at the normal scale of charges to enable it to pay operating expenses. This rate of occupancy is difficult to maintain in a small community when the hospital has sufficient capacity to meet peak load demands.

Most hospital authorities agree that no hospital of less than forty beds can expect both to give good service and to live on its income from patients. This is due partly to the fact that it can not derive sufficient income from such facilities as laboratories and operating and delivery rooms to cover the cost of their installation and operation and that of the specially trained personnel required to staff them properly. Since all critical points in a hospital must be staffed nights, days, and holidays, no matter how few pa-

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► The author, Dr. Warren P. Morrill, is director of research for the American Hospital Association. The editors of MEDICAL ECONOMICS, aware of the growing interest in small community hospitals, asked him to analyze their economic possibilities.

AHA Research Director Morrill and aide

tients are in the hospital, payroll cost is likely to be excessive.

Furthermore, a community of less than 10,000—the population that would justify a hospital of forty beds—is too small to support the number and variety of specialists needed to give adequate care to the sick. It has been estimated, for example, that a 40,000 population is required to support a radiologist, and that a population of 100,000 is necessary to support a pathologist. This would seem to force even the forty-bed hospital close to the substandard level, for in the absence of specialists the general practitioner is compelled to assume functions for which he has neither sufficient training nor proper facilities.

Some of the small hospitals try to get over this barrier to adequate medical service by employing "circuit riders," *e.g.*, specialists who try to serve a number of hospitals in large but sparsely populated areas. This is not always satisfactory. A specialist who is 50 or 75 miles away when he is needed in an emergency is of little use. It is improbable that even one of the 1,000-odd hospitals in the United States that have fewer than forty beds is equipped to provide fully for the community in which it is located.

This leads to a serious argument against the small hospital. The general public often cannot distinguish between adequate and inadequate facilities, and public sentiment and community pride tend to compel the use of a local institution by many patients whom it cannot adequately serve. The small local hospital renders a disservice to the citizens of its community to the extent to which this happens. Such a disservice, if recognized, would probably react against the institution to the extent of divesting it of its useful-

ness for even such community service as it can properly render.

Physicians who in their plans are assuming that government aid will sooner or later be granted to privately owned hospitals in small communities are courting disappointment. The Hill-Burton Bill, now before Congress, provides for Federal cooperation with the states in determining the hospital needs of community areas and their financial ability to provide for them. It also allows for the allocation of Federal funds to assist communities that are incapable of meeting the costs of the needed facilities by themselves. But it is quite certain that these funds will go only to non-profit institutions that are tax-exempt and relatively free of capital cost liabilities. This may in time bring hospital facilities to every community where there is a definite need for them, but it will not make the outlook for the privately owned institution any brighter.

There is no doubt about the present widespread lack of proper hospital facilities in small communities. It has deterred many physicians who want to practice in such communities from doing so. But they must face the fact that a community requiring less than forty beds for the care of its sick will rarely be able to support the special skills needed for good hospital service.

Small communities need hospital care of the quality available in our larger communities; but as yet, relatively few of them have become sufficiently aware of the costs involved to provide for them through tax or other community funds. In the absence of such support, the hospital with less than forty beds regrettably must choose between faulty care of its patients and financial disaster for itself.

—WARREN P. MORRILL, M.D.

'Minor' Operation Brings Malpractice Verdict

Court says failure to explain complications is actionable

Removal of the cyst on the woman's neck had looked easy. Hundreds of times, the surgeon had successfully performed this minor operation. In fact, he had told the patient that it could be done in ten minutes and that she would not be in the hospital for more than half an hour.

But after he had made the incision, he discovered that the growth was deep-rooted and in close proximity to the facial nerve. Without acquainting the patient with the seriousness of her case, he went ahead. His results, unfortunately, were bad.

In a malpractice suit which the patient subsequently instituted against him, she testified that as a result of the operation her mouth had been drawn to one side and her tongue partially paralyzed, that she could not eat properly, and that one eye was affected. Though she introduced no expert medical testimony while the defendant-surgeon did, the case was decided in her favor. The jury decided that the doctor had been remiss toward the patient when he neglected to inform her of the complications that had arisen and obtain her consent to a continuance of the operation.

—ELTON J. BUCKLEY, LL.B.

Health Workers Are Told How to Promote the W-M-D Bill

Stress benefits and build pressure on Congress, laborites urged

I was a little late. When I took my seat in the small, shabby meeting room of the hotel, the Rev. William H. Melish, a pale, fragile young man who was chairman of the conference, had already begun to speak. There were thirty or forty people in the audience, most of them women and all of them listening attentively. Four or five of the men were obviously young reporters.

It did not take long to get the drift of Mr. Melish's remarks. They suggested that about nine-tenths of the afternoon would be devoted to whooping up the Wagner-Murray-Dingell bill; and it was not necessary to wait long for the whooping to begin.

▶ As its name implies, the American Association of Health Workers ("for the promotion of labor health security, education, and legislation") is one of the articulate labor groups working for the passage of the Wagner-Murray-Dingell bill. Its health council, which is sponsored by the American Labor Party and trade unions, recently held a conference in New York. Here is a reporter's view of the proceedings.

The first speaker he introduced was Herman Seligson, a former instructor in social security at the Jefferson School of Social Science and an insurance counselor to the International Workers Order, a fraternal organization which follows the Communist line with great fidelity. Mr. Seligson was a short, swarthy man with a great air of logic. He described glowingly and at length the provisions of S.1606, shadow-boxed with its critics, and then undertook to answer some questions from the floor. That was a mistake. To the question, "What would be the status of such practitioners as osteopaths and optometrists under the Government program?" Seligson replied blandly that they would be regarded as specialists and that they were actually listed as specialists in the bill. There was an uneasy stir among those in the audience who apparently knew, as I did, that the bill contains no such list. One man growled audibly to another that he was going to "call the office about this damn nonsense."

But the social security expert was soon off on another track. Bluntly he told the health workers to refrain, for heaven's sake, from getting into arguments about socialized medicine. He said that when he

and some of his colleagues had been in Washington putting a little pressure on Congressmen to pass the W-M-D bill, or at least to get it out of committee, he'd been amazed at the legislators who had insisted on debating socialized medicine with him. Mr. Seligson was too shrewd for such traps, it seemed, and he warned his listeners to be just as canny. They were told that their job was to get the W-M-D bill on the statute books; that later its defects could be corrected with amendments. He offered a simple technique for selling the bill: Buttonhole every worker and recite the benefits that will accrue to him. Stress the benefits, skip the rest. Get every worker to write to his Congressman, demanding action.

After this exhortation, Mr. Seligson yielded the platform to Dr. John H. Cassity, president of the "liberal" New York Psychiatric Advancement Committee. Dr. Cassity, a nervous man given to extravagant gestures, started out by telling a number of hoary jokes, including the one about the psychiatrist who thought that all other psychiatrists were crazy. Dr. Cassity had the interesting theory that half the population, from five years of age upward, needs psychiatric guidance. Accepting that thesis, one could hardly quarrel with his contention that large, well-staffed clinics would have to bloom all over the land. Dr. Cassity confessed that he was in quite a pet about the brushing-off psychiatry had received when the W-M-D bill was framed. Financing of a vast psychiatric program should have been included, he thought. I started to ask where the Government would find enough psychiatrists to staff the clinics, but Dr. Cassity had to get back to his work in Bellevue Hospital and couldn't wait to answer questions.

By this time even the earnest young reporters had realized that they were hearing "Johnny One-Note" played over and over again in different keys. Most of them had given up making notes, and one, discovering that he had made quite a mess under his chair with cigarette ashes and butts, was stealthily trying to scrape them up into a neat pile with his foot. One health worker, a little old lady, was either deep in thought or fast asleep, and an intense group in a corner was writing chits and passing them around.

The next event was a performance by Durward Pruden, Ph.D., of New York University's School of Education. Perhaps Mr. Pruden had never heard "Senator Claghorn" on the radio; in any event, he looked a little blank at the giggle which ran through the audience after he had remarked confidentially that "Ah'm from the South." In fact, he was to look blank several times. Discoursing somewhat needlessly on the point that labor had made vast strides in the last forty years, he noted that in the "old days" capital always had the finest lawyers in the country while labor had practically no legal talent at all. "But that picture has changed," said Mr. Pruden. "Today, when the corporation lawyer goes into a labor dispute, he finds himself faced by a labor attorney who is just as shrewd, eloquent, and crooked—er, clever—as he is." Somewhat dismayed by the roar of laughter which rang out from the earnest but not humorless laborites, Mr. Pruden grinned ner-

vously and said, "Say, this is a labor meeting, isn't it? I'm not in the wrong room, am I?"

But his temerity in calling a spade a spade was refreshing. "What's all this pussyfooting about socialized medicine?" he wanted to know. "I think it's fine; I like socialized medicine." Then, as though he had decided that he'd been a little daring, he added: "But I won't talk about socialized medicine if it sounds subversive."

"I agree with people who are afraid of bureaucrats getting hold of the national medical program," he said. "I wouldn't let the politicians run it. But I wouldn't let the doctors run it either. That's a job for social scientists." I remembered that Mr. Pruden was a social scientist.

So the afternoon wore on. Workers were beseeched to go out and fight tooth and nail for the passage of the Wagner-Murray-Dingell bill; doctors and pharmaceutical houses were damned for their impertinence in opposing it. Finally, Albert Deutsch, columnist for Marshall Field's perpetually indignant P.M. and the lion of the afternoon, arrived. The pontifical Mr. Deutsch, I noted, is actually a boyish looking individual with a mop of unruly hair and a shy grin. But his shy appearance is misleading. When he got into his topic, "Health Protection for the Veterans," it became clear that Mr. Deutsch believed that Mr. Deutsch had almost singlehandedly effected the reform of the Veterans Administration. He dwelt at length on his own series of articles about the V.A. in P.M., but never mentioned Albert Q. Maisel and Charles Bolte, whose exposes in national magazines had created a national furore. His talk abounded with such phrases as "I told General Hawley that I would not be satisfied with this feature of the program," and "General Hawley assured me that my objection would be given immediate consideration."

On the whole, one gathered that Mr. Deutsch thinks doctors are fine, competent fellows, but not to be trusted *en bloc*. He said he had told General Hawley, the V.A.'s Acting Surgeon General, that he would accept "as an expedient" the plan to utilize private practitioners in the outpatient care of veterans. But he had also warned the Surgeon General to "keep an eye on the doctors," so that they wouldn't have a chance to indulge in all manner of chiseling and bill-padding. Such goings on, he declared, were a scandal back in the old Veterans Bureau days and more recently "had brought about the collapse of the compulsory system in New Zealand." Doctors can't be trusted to work on a fee basis, Mr. Deutsch implied; that's why it is asinine to give them the choice in S.1606. He would put them to work, instead, "on a salary or capitation" basis and make them like it. I began to wonder if that amendment had not already been drawn up and placed in the Wagner tickler file.

Only one speaker, James E. Bryan, executive secretary of the New York County Medical Society, sounded a discordant note at the conference. Mr. Bryan, one of organized medicine's keenest executives, is also a bear for punishment. Before he spoke he had listened to five or six digs from Mr. Deutsch and to a catty introduction by the chairman.

"Let us assume," Mr. Bryan asked his audience, "that your employers have decided to enforce upon you a new set of working conditions which 75 per cent of your members consider intolerable and dangerous. I imagine, from my superficial study of labor union matters, that you would fight such a movement with everything you have and that you would probably fight it effectively." (A few chins started to jut at this annoying comparison.) "Why then should you be surprised that organized medicine strenuously opposes a plan of medical care which it feels will injure medicine as a profession and seriously deteriorate the quality of medical care for the great mass of the American people?"

The question fell on the floor, and the audience let it lie there.

Mr. Bryan read his paper through to the bitter end. It was a surprisingly temperate, even conciliatory statement of the case, but the assembled health workers weren't having any, thank you.

When the speaking period ended, the floor was opened for discussion. I tentatively raised my hand to ask a question or two, but apparently the chairman, who'd been staring at me all afternoon, had suddenly acquired astigmatism. He immediately recognized Dr. Jacob A. Auslander, managing editor of the Health Council Digest and one of the discussion leaders for the conference.

Everything but compulsory sickness insurance got a quick brush-off from Dr. Auslander. Voluntary health plans were no good *per se*; they were no good because they were not comprehensive enough; they were beyond the financial ability of "a vast majority" of Americans (who, presumably, could afford a payroll deduction for Government insurance); they were no good because Dr. Auslander didn't like them. The Wagner-Murray-Dingell bill was perfect; what was the argument about? Doggedly, I raised my hand again. And again it might have been made of plate glass, for apparently nobody saw it and the afternoon session broke up abruptly.

I looked at my program and saw that more discussion was scheduled for the evening session. But the list of expected speakers indicated that it would be just more of the same. I reached for my hat and coat.

—ANDREW G. ROSS

Prostatightwad

A man in his seventies, known for his miserliness, came to my office. His opening remark was, "What is your charge?" I informed him and we proceeded with the examination. When I had finished and had learned that his symptoms were mainly referrable to his prostate, I said, "I would like to examine your prostate." "What's that?" he replied. I explained as well as I could, and then was asked, "Will that cost me any more?"—HAROLD B. PLUMMER, M.D.

Medical Education

Re-education Sought for 'Substandard' Men

The Massachusetts licensure laws had been tightened; no longer could graduates of unapproved medical schools be authorized to practice in the state. Unapproved Middlesex University School of Medicine had closed its doors.

Thus far the battle had been successful, but a Massachusetts practitioner, Dr. A. Wilson Atwood, pointed out that there were complications ahead. For example:

What was to be the attitude of organized medicine and of individual physicians toward "substandard" men already in practice, including many still with the armed forces? "We all agree, I believe," said Dr. Atwood, "that the fight against substandard schools is not a fight against their graduates who are now legally practicing. But a big job faces the profession as a whole, and the hospitals and medical societies in particular. In some way the educational facilities of these institutions should be made available to all doctors who are interested, even though they may not at present be eligible for full membership. There are indications that these doctors are anxious to improve themselves; that they are willing to cooperate on a frank and friendly basis."

The editors of the Worcester Medical News agreed. "Let us invite them to our meetings," they suggested. "Let us help them keep abreast of the times; let us watch their attitude, their intellectual curiosity and ethical standards; and as soon as their waiting period is over, take into membership those that pass our high standards."

As a starter, the Massachusetts Medical Society offered all legally qualified physicians in the state the privilege of attending its post-graduate extension courses.

Stovall Deplores Decline of Family Doctor

The decline of the family doctor, stemming from an overemphasis on specialists, presents a distinct threat to American health, Dr. J. Watts Stovall, president of the Kentucky State Medical Association, believes.

Dr. Stovall, who is concerned especially about the dearth of G.P.'s in rural areas, says that organized medicine is at fault because it makes little effort to prepare medical graduates for rural practice and gives little or no technical assistance to those who are willing to undertake it. A young doctor who emerges from his interneship dependent on consultative services, laboratory technicians, and other experts "is

utterly unfitted for independent rural practice. That is why so many medical graduates of today do not locate in small towns," Dr. Stovall says.

He believes that the older general practitioners knew more about human nature and understood their patients better than many modern medical graduates. "One sometimes wonders," he says, "if the bedside manner of former days may not have been as important to the patient as the medical science of today."

It is a regrettable fact, he adds, that the general physician of today does not measure up to the standards set by men of a generation ago. "What he has gained in the knowledge of medical science he has lost in the art of medical practice. And surely the need for the family physician is no less great than formerly. Women still bear children and rear them, too often in overcrowded apartment houses under conditions that foster the spread of diseases.

"Under the stress of modern life, the family physician is still the most valuable man of medicine to the individual, to the community, and to the nation. But the fact remains that there are fewer general practitioners today than there were twenty-five years ago, and who can say what the picture will be in another twenty-five years?"

How should young graduates be prepared for country practice? Dr. Stovall believes that each graduate, in addition to his interneship, should be required to practice for a year as the associate of an established practitioner in a small community before he is permitted to take state board examinations, which should include questions on his practical experience.

There would be much greater incentive for rural practice, Dr. Stovall believes, if organized medicine took an active part in providing the following:

¶ More and better public health facilities.

¶ More and better district general hospitals.

¶ A maternity center in each county.

¶ At least one medical technician in each county.

¶ A tuberculosis hospital in each district.

¶ Better roads.

¶ Blue Cross hospitalization plans for all the people for all types of illness.

Columbia Insists Dentistry is Part of Medicine

Is dentistry an integral part of medicine or is it an autonomous profession? The old question, no longer an academic one, has been debated with considerable heat since Harvard University merged its dental school with its school of medicine several years ago, and more particularly since Columbia University did the same thing last year. The American Dental Association has stricken both institutions from its list of approved schools, and not long ago the New Jersey State Board of Registration and Examination in Dentistry removed Columbia from its own approved list, as it had earlier removed Harvard.

Dr. Willard C. Rappleye, dean of

Columbia's College of Physicians and Surgeons, was unmoved. He described the action "as of no account to us." Of real importance, he said, was the status of the dental school in New York State. Apparently it was good, for Dean Rappleye had a letter from Irwin A. Conroe, of the New York State Education Department, to the effect that Columbia's program in dentistry was "second to none" and that the education department had no intention of changing its rating of the school.

The New York Times was caustic about the New Jersey blackball. "If Columbia's future dental graduates were unable to pass New Jersey examinations a strong case would be made out against the new conception of dentistry as a branch of medicine. But New Jersey judges the experiment in advance without knowing what the outcome will be. We are told that the 'autonomy of dental education' must be preserved, and yet no branch of medicine or surgery, not even nursing, is autonomous. Dentistry is as much a part of medicine as surgery or otolaryngology, and it is thus that Columbia properly regards it.

"New Jersey's state board is not consistent in its argument," the Times continued. "It does not 'doubt the ability of Columbia to graduate good products in the beginning' but it is already convinced that 'the product will suffer in the long-range program.' How does it know? If the 'product' will be good in the beginning, why not ten years hence? And where does it get the idea that dentistry is to be 'subjugated'? No one can maintain that surgery has been subjugated to medicine, or medicine to surgery, or bacteriology to the study of nutrition.

"Physicians often have a snobbish way of looking down on dentists," the Times noted in concluding. "It is time that dentists should be recognized for the highly trained professionals that they are—men and women who should rank with the best physicians and who should not stand apart. Columbia has taken a forward step. The inclusion of dentistry in the medical curriculum should result not only in better treatment of dental and oral defects, but in an improvement in the dentists' professional position."

Double Play

I had just delivered a healthy nine-pounder. "My," exclaimed the nurse, "I'll bet her daddy will be proud!" "Oh, he needn't get a swelled head," murmured the ether-groggy mother. "Dr. Mueller had more to do with it than my husband!"

An embarrassing silence descended, and I could feel my face reddening. But it was true: I'd given daddy an "assist." The mother had been able to conceive only after artificial insemination—with her husband the donor. —R. W. MUELLER, M.D.

Insurance Questions & Answers

An insurance specialist tells you what your policies are worth

Q. Is the diagnosis of coronary disease, *per se*, sufficient to warrant a claim of total and permanent disability?

A. No. Benefits are not payable merely because a policyholder has *contracted* a disease; he must be totally disabled by it. He is required to prove that the disease, to quote a typical contract, prevents him from "engaging in *any and every* occupation whatever for wage, profit, or remuneration." An ability to work even intermittently would invalidate a claim. To establish total disability, the policyholder must prove its continuity and the reasonable probability of its permanence. Permanent disability is assumed when satisfactory medical evidence is presented after the policyholder has been disabled for three, four, or six months, depending upon the insurance company.

Q. I have some spare cash that I don't care to invest in stocks or bonds. Could I save anything by using it to pay my life insurance premiums in advance? If not, should I put it into a single-premium annuity?

A. You cannot secure more than 2 per cent discount on premiums paid in advance. Some companies will not discount them at all. The single-premium deferred annuity, which requires a minimum investment of $1,000, is a safe depository for surplus funds. A few companies still offer such a contract. It is reasonably liquid, accumulates at a guaranteed rate of interest, and yields a lifetime income (at age 60) of slightly more than 6 per cent.

Q. Several younger members of our medical society plan to buy malpractice insurance for the first time. They ask: Who needs it most —and how much?

A. Few physicians can risk being without protection, even though the number of judgments rendered against the profession is negligible. (Some years ago, one of the larger carriers found that claims over a period of years totaled only 2.27 for every 100 doctors insured.) Definitely in need of such protection are: (1) ex-service physicians who have become stale in Army administrative jobs; (2) anyone transferring from general practice to a specialty; (3) specialists in neurosurgery, plastic or cosmetic surgery, and orthopedics; (4) any physician doing surgery without an extensive residency behind him; (5) any M.D. who is disposed to experiment with new procedures or methods without extensive training or in-

Handitip

Collection Nudge

In the belief that some patients need to be reminded of more than the date of their next appointment, I have devised a combination receipt and appointment slip. It measures 3½" wide x 2" high and has my name and address at the top. Underneath in neat arrangement are the following headings: date, patient's name, treatment, charge, paid, balance, and time of next appointment. Such a blank is easily filled in and handed to the departing patient. It informs him diplomatically of the amount he owes as well as of the time he is expected to call for a subsequent treatment. More often than not he will come back prepared to take care of the indicated unpaid balance.

—M.D., TEXAS

vestigation. The seasoned, conservative, well-trained G.P. need usually have little fear that a judgment will be taken against him. For him the minimum insurance limits ($5,000-$15,000) are generally adequate. Larger amounts might be recommended for surgeons and other specialists whose high-fee practices warrant the additional cost.

Q. Now that I'm out of the Army and about to enter civilian practice, I should like to drop some of my Government insurance. Would this be wise? I may wish later on to replace what I now drop with some form of commercial policy.

A. National Service Life Insurance should be retained if there is the slightest need for protection. No private company offers low-cost coverage under such liberal conditions. Under present law, the term insurance provided must be converted into ordinary life, twenty-payment life, or thirty-payment life within five years. But Congress may soon make the term contract renewable every five years. If this happens, it may be advisable to continue your NSLI policy in its present form.

Q. I am 35 years old and have a good practice. My wife is the same age. Our twin daughters are eight months old, and we shall not have any more children. I have a $5,000 straight life policy, which costs $143 annually, and term insurance of $10,000 for twenty years, convertible thereafter into $5,000 of ordinary life costing $204 annually. I want to increase my total protection, now $15,000, to $25,000, and get maximum protection for my premium dollar during the next twenty-five years. Shall I convert everything into term insurance or buy additional straight life?

A. Your protection needs are greatest today; they will decrease as your children grow older. In such a situation, level-premium reducing term insurance is often a good buy; it provides pure protection with no loading of the cost to provide cash-surrender values. The premium remains constant to age 60-70 (optional) the face value of the policy is reduced each month you live; but the insurance remaining in force is always sufficient to give the beneficiary the amount of monthly income originally purchased. To illustrate:

For an annual premium of $423, your family would be assured a monthly income of $200 from the date of your death until the time you would have reached age 65. (Thus, if you died at age 40, your beneficiaries would receive $60,000, or $2,400 a year for 25 years.) At age 65, when the insurance terminates, your daughters should be economically independent. Without saddling yourself with large fixed premiums during your best earning years, you should be able to put enough into bonds or annuities to provide for your wife's future should she survive you.

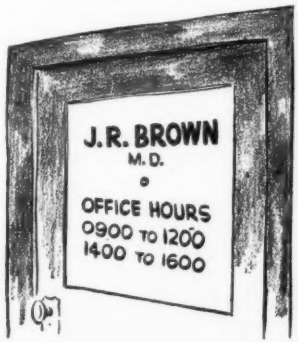
Your present commitments total $347 a year. The purchase of a $10,000 ordinary life policy instead of the level-premium term contract would increase your annual premium outlay to about $642 (less dividends).

Q. If a commercial policyholder has become totally disabled during his Army career, are his premiums waived from the time of his injury or from the date of his separation from the service?

A. Premium-waiver clauses are not uniform. In most cases, the carriers are relieved of liability for any injury or illness incurred by the policyholder while in the armed services. If the premium-waiver clause becomes effective at all, the time is set forth in the policy. The policy also establishes a time limit for filing a claim. The limit is not determined by state law, contrary to what many people believe. A claim generally must be made (a) during the period of the insured person's disability and (b) within six months of the time any due premium was in default.

Q. I have a sizable annuity which matures in five years. Is it worth my while to retire this policy now at a 2 per cent discount?

A. If the company is willing to discount the five remaining annual premiums at 2 per cent *compound interest,* it would be advisable to accept. In a savings bank, the money would probably yield less than 2 per cent. Discounting the premiums, however, would not "retire" the policy; it would simply spare



you the bother of meeting the obligation annually for five years. Be sure that you will have the right to withdraw any "unearned" portion of the sum deposited should a need for cash arise; be sure, also, that the discounted premiums will be refunded to your beneficiary if you do not live out the five-year period. An annuity gives you a lifetime income at any age you choose prior to or at maturity. The maturity date is generally 55, 60, or 65. If at the maturity date you have reached age 60, you may be wise to exercise the "20-year fixed installment option" which permits you or your beneficiary to receive a fixed amount regularly over a twenty-year period. Such a settlement invariably gives the policyholder a greater total return than does an annuity for life.

Q. My income averages about $800 gross a month. I have an accident and health insurance policy that pays $200 a month. Do you consider that enough protection? My age is 37.

A. The possibility of incurring a degenerative disease that results in prolonged disability is rather remote for a man of your age, and the average M.D. is usually able to finance short-term illness. Accident and health insurance should be carried in an amount sufficient to meet inescapable domestic and professional expenses. If you gross $800 monthly, and your fixed expenses are, say, $600, the difference, or "profit," need not be insured. If and when health insurance is desired it should be purchased on a non-cancellable basis, with provision for *full* benefits whether or not the policyholder is house-confined. You may run into some difficulty in finding companies willing to participate in an amount of health and accident insurance exceeding $500 or $600 a month. —W. CLIFFORD KLENK

Dead End

I was scrubbing in preparation for a hemorrhoidectomy when an interne informed me that he had just discovered a large mass high in the ampulla of my patient's rectum. Incredulous, for I had examined the woman carefully, I followed the interne to one of the operating rooms. The nurse produced a glove and I proceeded to do a rectal.

The examination was difficult, for the patient squirmed and protested loudly. I found nothing, changed gloves, and did a vaginal, to no avail. Then the interne did a rectal and a vaginal. Still nothing. "I must have been mistaken," he admitted sheepishly.

As we turned to leave the room, in walked a nose-and-throat man—capped, gowned, and scrubbed for a tonsillectomy on his patient. *My* patient was in the next room!

—DEANE B. BRENGLE, M.D.

Osteopaths' Technique Revealed in Congressional Debate

How three-point argument succeeded in fight to obtain V.A. jobs

"Little by little the osteopaths are demonstrating that there are more ways than one to manipulate legislative vertebrae."

This opinion, expressed by a spokesman for medicine, was amply confirmed recently when Congress enacted Public Law 293, which, among other things, makes osteopaths eligible for appointment to posts in the Veterans Administration. According to political observers, a well planned technique, which had previously been successful in various state legislatures, helped immeasurably in putting the concessions to osteopaths into this law. The osteopaths succeeded in Washington, as they had in the states, by heavily emphasizing three points:

¶ That osteopaths are being discriminated against by the medical profession.

¶ That Congress, which gave some recognition to osteopathy in provisions of the G.I. Bill of Rights, the EMIC program, and other measures, must be consistent and accord further recognition (in this case, for the care of veterans).

¶ That the requests of V.A. patients for osteopathic service are strongly supported by national veterans' groups.

The charge of discrimination was especially effective. Representative Hoffman (R., Mich.) accused the AMA of acting as though it "did not want anybody to practice medicine except a few hand-picked individuals." A little later he observed, "If I had my way, and the veterans wanted him, and he was available, I would have old Bob, who presides down here in the gymnasium, aid them, because he has helped many a member, including myself, when a physician was not at hand or could not or did not relieve us."

Some Congressmen made an issue of the fact that most of their colleagues who opposed the measure were physicians. "They have an ax to grind," commented one member of the House. "Personally, I think their stand is a selfish one and it is indefensible. We are here today to legislate for the veterans and not for the doctors."

"I have not seen so many doctors on the floor for some time," added Congressman Savage (D., Wash.). "These doctors are loyal. They are loyal to the fight that has been going on for years and years . . . trying to maintain a monopoly on doctoring people. In the past this may have been a just fight because there have been many things that were not of

high standard. But let me call to your attention the fact that an osteopath at the present time in many states has to take the same training that a medical doctor does and, further, take two or three years of special training in osteopathy. They use a great many electrical gadgets, and so forth, that medical doctors cannot safely use unless they, too, take some osteopathy."

Members of Congress were not impressed by the fact that Maj. Gen. Paul R. Hawley, Acting Surgeon General of the V.A., was on record as opposing the measure. In a letter to Representative Fenton (R., Pa.), General Hawley had written that "it would be impossible to integrate into one efficient medical service for the Veterans Administration a school of healing which holds tenaciously to the theory that most, if not all, human ailments are the result of dislocations of the vertebrae."

Congressional advocates of osteopathy denied that confusion might result from having two schools of medical thought operating within the V.A. Here, the fact that Congress had already established a precedent proved to be a highly conclusive argument.

"This is not an untried Government policy," contended Congressman Bennett (R., Mo.). "There was no confusion during this war in the Army and Navy hospitals. There has been no confusion from the United States Employment Compensation Act, under which civil service employes are given the right to use doctors of osteopathy. There was no confusion when legislation which every one of you voted for enabled doctors of osteopathy to be paid out of the Treasury to deliver the babies of our veterans. What is good for the serviceman should be good for him when he takes off his uniform and becomes a veteran. All of you voted to enable him to study osteopathy at Government expense under the G.I. Bill of Rights. Let us be consistent."

Enlarging upon this theme and exploiting the influence of the veterans' organizations, Congressman Scrivner (R., Kan.) said that he had attended meetings of the American Legion's rehabilitation committee at which opinion was "almost unanimous" that both osteopathy and chiropractic should be made available to veterans who wished such services. "Thousands of veterans" were trained as osteopaths and chiropractors after World War I, he said, and the Legion representatives expected "still more thousands" to be so trained in the coming years. If these schools of thought had no scientific value, the V.A. "should not be spending the taxpayers' money to educate the returning veterans in those two professions," he declared.

To show further that veterans' organizations had long urged V.A. acceptance of osteopathy, Congressman Shafer (R., Mich.) read into the record a resolution to that effect passed in 1937 by the Disabled American Veterans of World War I.

Against this attack, the arguments presented by physician-representatives gained only limited support. Nevertheless, the debate adduced facts which the physicians present hoped would not be overlooked by the medical profession in future legislative battles.

According to Representative Domengeaux (D., La.), a member of

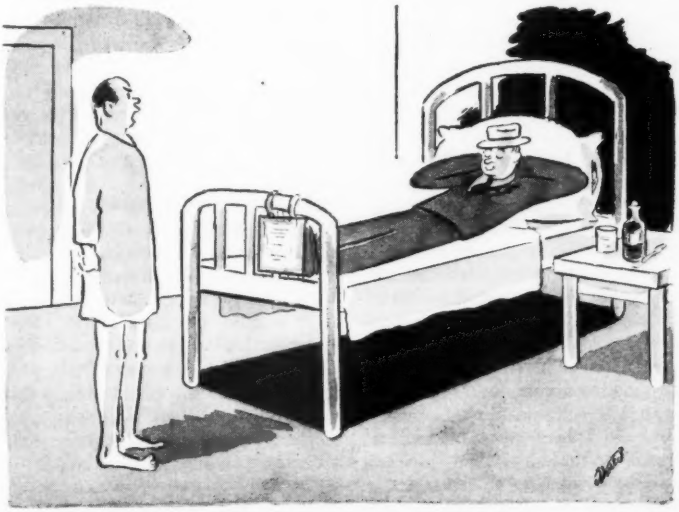
the committee before which hearings on the bill had been held, Dr. Ralph Fisher of the Philadelphia College of Osteopathy had been among those carefully questioned. "I recall," said the Congressman, "having asked him, 'What contribution has your profession made to the advance of surgery and medicine?' And the doctor, who is the head of the organization, said, 'I do not know.' "

Dr. Fisher was also quoted as having said, "If the professional organizations would leave the doctors alone, the doctors of medicine and the doctors of osteopathy would get along all right. Most of this friction talk is a bugaboo and a red herring anyway."

The House was unmoved by the argument of physician-Congressman Miller (R., Neb.) who pointed out that an osteopath does not do anything that a physician cannot do and that the entire field of healing is covered by the regular physician and surgeon. It was equally unmoved by the statement of physician-Representative Hedrick (D., W.Va.) that in many parts of the country osteopaths are reported to be practicing outside the field in which they have been trained, and that if they would limit their practices to conform with their training the medical profession would have no objection.

Dr. Hedrick's amendment to have the osteopaths excluded from V.A. jobs was defeated, 65 to 29.

—MELVIN SCOTT



"YOU'LL HAVE TO GO NOW. VISITING HOURS ARE OVER."

When Is Abortion a Crime?

Here are the legal responsibilities of the doctor and his patient

Most state laws defining the crime of abortion fall into a single pattern. They prohibit the administration of any drug or substance and the use of any instrument or other means for the purpose of producing a miscarriage.

At common law an abortion induced with the mother's consent before the child quickened was not a crime. It was held that the child was not "in life." It did not therefore have legal existence.

Our state laws do not make this distinction. An abortion induced at any stage of pregnancy is unlawful —unless the motive is to save life.

It is on this last point that most abortion cases turn. Since therapeutic abortions are legal, the fact that one has been induced does not by itself constitute evidence of criminal malpractice. The prosecution must establish the presence of non-therapeutic, or criminal, intent before there can be a conviction.

"It is well known," declares a widely accepted legal opinion, "that occasion arises where, in the exercise of proper surgical advice and care, it becomes necessary to remove the unborn fetus in order to save the mother's life. To such highly honorable and proper acts . . . the statute has no application."

This opinion has been the basis of most court decisions. An Oregon court, for example, ruled that proof that a physician "had used means to destroy a child" was not evidence of criminal abortion even if it resulted in the death of the mother. "Cases have often arisen in which such treatment has necessarily been resorted to," the ruling said, "and in the absence of other proof, the law in its benignity would presume that it was performed in good faith, and for a legitimate purpose."

It should be noted that often good faith alone is not regarded as an adequate defense. The court may question the physician's judgment; that is, whether he was justified in deciding that abortion was necessary to save his patient's life.

In a Washington case, a physician testified that the patient, a schoolgirl, had an accelerated pulse

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▶ Emanuel Hayt, the author, is a member of the New York Bar and of the Society for Medical Jurisprudence. He is also an associate member of the American Hospital Association. While specializing for the last fifteen years in medical and hospital law, he has written several books and contributed numerous articles to medical and hospital journals.

and a rising temperature, and that she was flowing. He said this showed an infection for which he thought a curettage necessary. His testimony was corroborated by the attending nurse. But a witness for the prosecution insisted that at no time had the physician taken the patient's pulse or temperature, and that she had been well and going to school until the day of the operation. The jury found that the curettage was not necessary to save her life and that the doctor had not used his best judgment and skill.

A North Dakota court, ruling on a similar case, was more emphatic: "The standard by which to determine the necessity under the statute is not the good faith or bad faith of the physician, nor does it vary with the degree of skill which he possesses," it said. "It is the one standard of necessity."

Obviously, "necessity" is open to various interpretations. The conviction of an Iowa physician who had induced an abortion was later reversed when another court decided that it was not essential that the peril to the patient's life be imminent, but only that it be potentially present. The physician had testified that "there was no life in the fetus," and that had he not produced miscarriage the result might have been "death by blood poisoning."

There are variations in the wording of state laws and, though they may sometimes appear trivial or even absurd, they determine legal procedure in important ways. For example, where the law makes it a crime to induce, or attempt to induce, abortion in a pregnant woman, the prosecution must prove the fact of pregnancy. (California, Missouri, Iowa, New Jersey, Oklahoma, and Pennsylvania have such laws.) In an Oklahoma case the peculiar wording of the law saved a physician from being victimized by persons who, after persuading him to give advice and drugs to a "pregnant woman," recorded his conversation with her on a hidden dictograph and turned the "evidence" over to the authorities. He was convicted, but the conviction was subsequently reversed on the ground that the prosecution had not proved that the woman was pregnant when the recorded conversation took place.

In the District of Columbia, a physician was sued for breach of contract by an aborted woman who alleged that he had agreed to produce a miscarriage and to give her proper treatment, but had failed to do so; she also alleged negligence. The jury brought in a verdict of money damages. The doctor, who had made no claim that the abortion was necessary to save life, appealed. The higher court reversed the decision, holding that "Where an action is founded upon an unlawful contract, the court will not interfere to relieve either of the parties . . . from the results thereof. If the act out of which the cause for action arises is immoral and illegal, the court will not grant relief."

There have been many similar decisions. Perhaps the clearest of these is one by a Kentucky court that reads: "It may be stated generally that the suit of a wrongdoer will be rejected when seeking redress for another's having participated with him in the wrong."

—EMANUEL HAYT, LL.B.

Permanent Role Seen for Private Physicians in V.A. Program

Utilization of doctors throughout nation probable in near future

Private practitioners in four states are now acting as "fee-designated physicians" of the Veterans Administration in providing outpatient medical care on a voluntary fee basis for veterans with service-connected disabilities. And this is only the beginning. Indications are that the new V.A. policy of utilizing private practitioners will speedily bring about similar contracts in the other states.

Col. J. C. Harding, acting director of the V.A.'s outpatient service, told MEDICAL ECONOMICS that it would intensify its efforts to build a staff of 5,000 salaried, full-time physicians. But, he added, "I do not believe we'll reach a point in our lifetime where we can render all the services necessary with just our own salaried doctors." The colonel is of the opinion, therefore, that private, outpatient care will remain a permanent feature of the V.A. medical program.

In three of the four pioneering states—New Jersey, California, and Michigan—the state medical societies utilize existing prepayment plans as non-profit agencies to administer contracts with the V.A. In Kansas, the fourth state, participating physicians are paid directly by the Veterans Administration.

Typical of the outpatient programs is that of New Jersey, which is managed by the state society's prepayment plan, Medical Service Administration. Here is how it works:

Any member of the state medical society may become a participant in the veterans program after registering as such with the MSA. He must agree to limit his fees for the care of veterans to those stipulated in the schedule drawn up by the MSA and approved by the V.A. The schedule (which accompanies this article) includes in each fee 8 per cent for administrative costs which is deducted upon payment of the physician rendering the service.

The veteran may select his doctor from among any of the physicians participating in the program, except in cases requiring specialist examination. Then, selection is limited to doctors qualified in the specialty.

Veterans requiring examination for pension purposes are referred to private physicians. This method, it is felt, will better meet the needs of veterans in New Jersey than would the establishment of medical examination clinics in each county. However, any county society may operate such a clinic. The Monmouth County (N.J.) Screening Clinic which was the first effort of organized medicine to evolve a solution

of this problem will be continued as part of the state-wide plan.

Medical care of the sick veteran, as authorized by the V.A., may be rendered in the patient's home, in the physician's office, or in a community hospital. In either case, the V.A. pays the MSA for all authorized services rendered by the participating physician. The MSA in turn pays the doctor.

Ordinarily, authorization for treatment is obtained by the veteran from the V.A. before reporting to his physician. In emergency cases where there is reasonable, presumptive evidence of service connection, the V.A. regional office may authorize treatment and assume responsibility for payment for services until such time as the veteran's claim is formally adjudicated. If the claim of the veteran is disapproved, payment for services rendered after that time will not be made. This means, according to Colonel Harding, that the veteran's own word will carry a good deal of weight, unless, of course, his statements are patently unreasonable. Chronic inflammation of the appendix might thus be assumed to be service-connected; a fractured ankle incurred in civil life would not.

The physician bills the MSA according to the approved fee schedule which is effective for all of New Jersey. (Each state society presents its own schedule for V.A. approval.) Payment is made directly to the doctor by the MSA which is reimbursed monthly by the V.A.

Red tape and delay have been cut appreciably. Such minor annoyances as the notarizing of bills has been eliminated. The MSA, in making up the required forms, has kept them as brief as possible. It assumes responsibility for seeing that each form is properly filled out before forwarding it to the V.A.

Trouble is anticipated with physical examination forms as submitted by physicians. They must be complete, warns the MSA, and contain such information as will assist V.A. rating boards in determining the degree of disability suffered by the veteran.

The cost of drugs and appliances is also met by the V.A. At present, drugs are obtainable by the veteran only by forwarding the doctor's prescription to the V.A. regional office. It is hoped that a method can be developed by which emergency prescriptions can be filled in the community.

The MSA declares that standards of medical care rendered the veteran are a responsibility of the profession. A Veterans Administration liaison committee has been established in each county society.

The functions of these committees

Handitip

Silver Nitrate Stains

To remove hand stains resulting from the use of silver nitrate, a reader from Antioch, Ill., suggests the following: (1) Paint with tincture of iodine to precipitate the silver salt; (2) remove iodine with alcohol or household ammonia.

A Conroe, Texas reader finds S.S. Pot. Iodide also effective.

Stains should of course be removed within a short time.

will be as follows:

¶ To assure the adequacy of medical services rendered by participating physicians.

¶ To discipline physicians whose actions threaten the interest of the profession, the veteran, or the V.A.

¶ To hear appeals of the V.A., of veterans, or of physicians.

While osteopaths may treat veterans under V.A. regulations, no provision for their services had been made a month ago in any of the state plans. —JOHN COBB

FEE SCHEDULE FOR MEDICAL CARE OF VETERANS UNDER SERVICEMEN'S READJUSTMENT ACT, EFFECTIVE IN NEW JERSEY, MARCH 1, 1946

The amount payable for any service not included below will generally be consistent with those listed and will be determined by the Medical Service Administration of New Jersey (prepay plan) and approved by the Veterans Administration. Fees listed as applicable to surgical care in hospital include up to sixteen days' routine post-operative care in hospital, after which payment on an approved medical-call basis will apply.

First hospital visit	$ 5.40
Daily hospital visit	3.25
Subsequent hospital visit on same day, if approved	1.60
Formal consultation, home or hospital	10.80
House visit, not over 3 miles from office	3.25
House visit, over 3 miles from office (plus 75 cents for each mile over 3)	3.25
Night house visit, call received and visit made between 8 P.M. and 7 A.M. (plus 75 cents for each mile over 3 miles)	6.50
Office visit, with treatment	3.25
Office visit, with treatment by specialist where specialist's care is specified by Veterans Administration	5.40
Surgical assistant (payable for services rendered by private civilian physician in surgical procedures listed at a fee of $50 or more)	10.80

ABDOMINAL SURGERY

Esophagoscopy	54.00
Esophagoscopy and biopsy or removal of foreign body	81.00
Gastroscopy	54.00
Liver abscess	124.20
Abdominal fixation for prolapse of rectum	124.20
Anastomosis, intestinal	135.00
Anastomosis, uretero-intestinal, one stage	162.00
Anastomosis, uretero-intestinal, two stage	162.00
Appendectomy	108.00
Cholecystectomy	151.20
Cholecystotomy	135.00
Choledochotomy	162.00
Colostomy	81.00
Esophagus, dilatation by means of bougies	32.40
Fulguration, tumor—bladder, trachea, or esophagus (minor)	48.60
Gastrectomy, partial	189.00
Gastroenterostomy	162.00
Herniotomy, diaphragmatic	189.00
Herniotomy, ventral, inguinal, or femoral—single	108.00
Herniotomy, ventral, inguinal, or femoral—bilateral	135.00
Hysterectomy, abdominal or vaginal (including or excluding removal of adnexa)	162.00
Intestinal obstruction, operation for	108.00
Laparotomy, exploratory	108.00
Laparotomy and drainage, general peritonitis	108.00
Litholapaxy	81.00
Meckel's diverticulum, excision of	135.00
Papilloma of bladder, excision by cystotomy	81.00
Paracentesis of abdomen	10.80
Paracentesis of pericardium	27.00
Pyelotomy, with removal of calculus	135.00
Pyloroplasty	162.00
Splenectomy	162.00
Tumor, abdominal, removal of	108.00
Tumor, gastrointestinal tract, resection	189.00
Ulcer, gastric or duodenal, operation for	135.00

AMPUTATIONS

Upper arm	135.00
Forearm	108.00
Finger, one	27.00
Fingers, each additional	10.80
Foot	135.00
Hand	108.00
Leg	135.00
Thigh	162.00
Toe	27.00
Toe, each additional	10.80

ANESTHESIA

Anesthesia, by inhalation or continuous spinal, for the first hour	10.80
Anesthesia, by inhalation or continuous spinal, for each additional hour or fraction thereof	5.40
Anesthesia, spinal	10.80
Anesthesia, intravenous	10.80
Intratrachial anesthesia, first hour	16.20
Intratrachial anesthesia, each additional hour or fraction thereof	8.10

DISLOCATIONS

Carpal bone, one	43.20
Carpal bone, each additional	10.80
Clavicle	43.20
Elbow	54.00
Finger, one	5.40
Fingers, each additional	5.40
Hip	64.80
Knee	64.80
Mandible	27.00
Metacarpal bone, one	27.00
Metacarpal bones, each additional	10.80
Metatarsal bone, one	27.00
Metatarsal bones, each additional	10.80
Patella	54.00
Rib—on basis of home, hospital, or office calls	
Shoulder	43.20
Shoulder, recurrent or habitual (non-oper.)	54.00
Tarsal bone, one	27.00
Tarsal bones, each additional	10.80
Thumb	16.20
Toe, one	16.20
Toes, each additional	10.80
Vertebra, one or more	108.00

EXAMINATIONS

Dermatological	6.50
Electrocardiogram, with interpretation	10.80
Ears, nose, and throat (separately or together)	5.40
Ear, including audiometric test with chart	10.80
Ear, including either caloric or Barsny test or both, with report	10.80
Eyes (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings, the latter by chart in all cases of optic atrophy)	10.80
Eyes, with refraction if mydriatic is used (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings, the latter by chart in all cases of optic atrophy)	13.50
Eyes, ears, nose, and throat with refraction (with or without mydriatic)	16.20
Genitourinary, without cystoscopy	5.40
Gynecological	5.40
Complete examination of heart, including electrocardiographic interpretation	16.20
Heart or lungs	5.40
Neurological	10.80
Neuropsychiatric	16.20
Orthopedic	5.40
Physical, to determine need for hospitalization	3.25
General routine physical	5.40
Proctoscopy or sigmoidoscopy	10.80
General surgical	5.40
Ventriculography, air injection through skull for diagnostic purposes (not including x-ray)	43.20

COMPOUND FRACTURES

Carpal bone, one	108.00
Carpal bones, each additional	16.20
Clavicle	108.00
Coccyx (Coccygectomy)	81.00
Femur	135.00
Femur, when suture, plating, nailing, or extension	162.00
Fibula	108.00
Fibula, suture or plating	135.00
Finger, one	27.00
Fingers, each additional	10.80
Humerus	135.00
Humerus, suture, plating, or extension	162.00
Malar bone	81.00
Mandible (wiring if necessary)	108.00
Metacarpal bone, one	54.00
Metacarpal bones, each additional	10.80
Metatarsal bone, one	54.00
Metatarsal bones, each additional	10.80
Nasal bones	32.40
Patella	108.00
Patella, suture or plating	135.00
Pelvis	108.00
Pelvis, suture or plating	162.00
Radius, ulna, or both	59.40
Radius, ulna, or both, suture or plating	135.00
Rib, one	54.00
Ribs, each additional	5.40
Sacrum	81.00
Scapula	54.00
Skull, vault	135.00
Sternum	162.00
Tarsal bone, each	108.00
Tarsal bones, each additional	16.20
Tibia	81.00
Tibia, suture or plating	108.00
Tibia and fibula	81.00
Tibia and fibula, suture or plating	135.00
Toe, one	27.00
Toes, each additional	10.80
Vertebra, one or more	135.00

SIMPLE FRACTURES

Carpal bone, one	54.00
Carpal bone, each additional	5.40
Clavicle	43.20
Coccyx—on basis of home, hospital, or office calls	
Femur	108.00
Femur, suture, plating, or extension	162.00
Tibia or fibula, including Potts' Fracture	81.00
Tibia or fibula, including Potts' Fracture, suture or plating	135.00
Finger, one	27.00
Fingers, each additional	5.40
Humerus	81.00
Humerus, suture, plating, or extension	135.00
Malar bone	27.00
Mandible (wiring if necessary)	81.00
Maxilla superior (wiring if necessary)	81.00
Metacarpal bone, one	43.20
Metacarpal bones, each additional	5.40
Metatarsal bone, one	43.20
Metatarsal bones, each additional	5.40
Nasal bones	27.00
Patella	43.20
Patella, suture or plating	135.00
Pelvis	81.00
Pelvis, suture or plating	162.00
Radius or ulna, including Colles' Fracture	43.20
Radius or ulna, including Colles' Fracture, suture or plating	135.00
Rib, one—on basis of home, hospital, or office calls	
Sacrum—on basis of home, hospital, or office calls	
Scapula	43.20
Sternum—on basis of home, hospital, or office calls	
Tarsal bone, one	54.00
Tarsal bones, each additional	5.40
Toe, one	27.00
Toe, each additional	5.40
Vertebra, one or more	108.00

GENERAL SURGERY

Adenectomy, cervical, inguinal (minor)	10.80
Adenectomy, cervical, inguinal (radical)	70.20
Biopsy	10.80
Breast, resection of (simple)	81.00
Breast, resection of (radical)	135.00
Carbuncle, excision of	27.00
Deep abscess, including ischio-rectal	54.00
Superficial abscess	5.40
Femoral artery, ligation of	54.00
Fulguration of tumor, superficial	16.20
Ingrown toenail, excision of	27.00
Thyroid artery, ligation of	81.00
Thyroidectomy	135.00
Tumor or cyst, deep, removal of	27.00
Tumor or cyst, superficial, removal of	10.80
Varicose veins, injection treatment, each	3.25
Varicose veins, one leg, operation for	54.00
Varicose veins, both legs, operation for	81.00
Pilonidal cyst, excision of	54.00

JOINT RESECTIONS

Elbow joint, excision of	162.00
Hip joint, excision of	162.00
Knee joint, excision of	162.00
Shoulder joint, excision of	162.00
Wrist joint, excision of	162.00

LABORATORY EXAMINATIONS

BACTERIOLOGICAL

Cultural, for fungi	5.40
Microscopic, for fungi	2.15
Pneumococcous typing	5.40
Pus or exudate, smear	1.10
Pus or exudate, cultural, classification	5.40
T. Pallidum (dark field)	5.40
Throat culture, classification of organism	5.40
Throat smear	1.10

BLOOD

Agglutination test for typhoid, paratyphoid or undulant fever	2.15
Bleeding time	1.10
Blood calcium	3.25
Blood chlorides	3.25
Blood culture, including classification	5.40
Blood platelet count	1.10
Blood smear for malaria	2.15
Blood typing (grouping)	1.10
Carbon dioxide combining power of blood plasma	5.40
Chemical examination of blood, complete, including creatinin, dextrose, urea, nitrogen (or non-protein N), and uric acid	16.20
Cholesterol	3.25
Coagulation time	1.10
Complement fixation test—gonococcus infection	3.25
Complement fixation test for syphilis	3.25
Complement fixation test for tuberculosis	3.25
Creatinin	3.25
Dextrose	3.25
Total erythrocyte count	2.15
Fragility test for erythrocytes	5.40
Hemoglobin estimation	2.15
Hydrogen iron concentration	5.40
Differential leucocyte count	2.15
Total leucocyte count	2.15
Complete blood count, including total counts	5.40
Non-protein nitrogen	3.25
Occult blood	1.10
Blood phosphorous	2.15
Precipitation, test for	2.15
Reticulocyte count	2.15
Sedimentation rate	2.15
Estimation of sugar tolerance	10.80
Urea nitrogen	3.25
Uric acid	3.25
Van den Bergh test for icterus	2.15
Volume index	3.25

FECES

Cultural, for causative micro-organism (classification of bacterium)	8.10
Fat in feces	1.10
Parasites and ova	5.40

PATHOLOGICAL

Autopsy, complete, with report, including histological examination	54.00
Tissue, with report	5.40

SKIN TESTS

Protein sensitization tests (series), including allergens, for purpose of establishing causative factor	27.00
Tuberculin	3.25

SPINAL FLUID

Examination of spinal fluid for causative organism, smear	3.25
Call count	2.15
Colloidal gold reaction	3.25
Complement fixation test for syphilis	3.25
Cultural exam of spinal fluid, including classification of causative micro-organism	5.40
Globulin test	1.10
Complete exam of spinal fluid, including complement fixation test, colloidal gold, globulin test, and cell count	10.80
Precipitation test for syphilis	3.25

SPUTUM

Tubercle bacillus, plain smear	3.25
Tubercle bacillus, concentration method	5.40
Exam of duodenal content for pancreatic ferments	3.25
Exam of gastric content for acidity, by histamine	3.25
Exam of gastric content for pepsin	3.25
Routine chemical, including test seal with withdrawal of stomach contents	10.80

URINE

Chemical examination, routine	1.10
Chemical and microscopical examination	2.15
Chlorides	3.25
Creatinin	3.25
Cultural exam, including classification of microorganism	5.40
Hydrogen iron concentration	1.10
Mosenthal test	2.15
Total nitrogen	3.25
Renal function test, including phenosulphonephthalein	3.25
Tubercle bacilli	3.25
Urea nitrogen	3.25
Uric acid	3.25
Urobilin	1.10

OTHER EXAMINATIONS

Animal inoculation for diagnosis, with report of autopsy	10.80
Preparation of autogenous vaccine	10.80
Determination of basal metabolic rate	5.40

MISCELLANEOUS

Blood transfusion, administration only, without venesection	10.80
Non-surgical drainage of gall bladder	10.80
Electrocardiograms, interpretation of	5.40
Hypodermoclysis	3.25
Injection of alcohol, trigeminal nerve	27.00
Intravenous injection, exclusive of cost of drug	3.25
Application of plaster cast, chest	16.20
Application of plaster cast, thighs and hips	27.00
Application of plaster cast, thigh and leg	10.80
Application of plaster cast, torso	27.00
Application of plaster cast, torso and hips	32.40
Application of plaster cast, entire body	54.00
Application of plaster cast, entire body in hyper-extension	108.00

NEUROSURGERY

Encephalography, air injection by spinal route for diagnostic purposes	27.00
Brain abscess	162.00
Chordetomy	162.00
Casserian ganglion, excision of	162.00
Laminectomy	162.00
Nerve, suture of	108.00
Supraorbital nerve, injection of	16.20
Neuroma, resection of	54.00
Cisterna puncture, including local anesthesia and obtaining fluid	27.00
Lumbar puncture, including local anesthesia and obtaining fluid	10.80
Skull, decompression of	108.00
Sympathectomy, cervical or lumbar	162.00
Sympathectomy, periarterial	108.00
Tumor of brain, operation for	216.00

NOSE AND THROAT

Oral abscess, not including dental or peridontal	10.80
Adenoidectomy	21.60
Antrum, intranasal, drainage of	21.60
Antrum, radical, operation for	108.00
Cleft palate, operation for	108.00
Harelip, operation for	81.00
Intubation, laryngeal	27.00
Laryngectomy	162.00
Larynx, cauterization of	27.00
Tumor of larynx, removal of	108.00
Nasal polypus, removal of	21.60
Nasal septum, submucous resections of	54.00
Pharyngeal abscess, operation for	21.60
Accessory nasal sinuses, irrigation of	10.80
Ethmoid sinus, radical, operation for	81.00
Frontal sinus, intranasal, drainage	54.00
Frontal sinus, radical, operation for	108.00
Sphenoid sinus, drainage of	54.00
Tonsillar abscess, operation for	21.60
Tonsillectomy	43.20
Tonsillectomy and adenoidectomy	48.60
Tracheotomy	54.00
Turbinate bone, galvano-cauterization of	21.60
Turbinectomy	27.00

OBSTETRICS, GYNECOLOGY

Pregnancy, delivery only—spontaneous	54.00
Pregnancy, delivery only—low forceps	70.20
Pregnancy, delivery only—mid forceps or version	81.00
Miscarriage, to six months	21.60
Miscarriage, to six months (with D & C)	32.40
Miscarriage, after six months	43.20
Caesarean section, vaginal or abdominal	108.00
Pregnancy, extopic (also ruptured)	135.00
Bartholin's Gland, incision	10.80
Bartholin's Gland, excision	32.40
Urethral caruncle, removal	16.20
Labial tumors and cysts, removal	27.00
Atresia of vagina, correction of	54.00
Perineorrhaphy	54.00
Colporrhaphy, anterior	54.00
Fistula, recto- or vesico-vaginal	108.00
Cul-de-sac, drainage	54.00
Cauterization of cervix	21.60
Dilatation and curettage	32.40
Tubal inflation	16.20
Uterine polypi, removal	27.00
Trachelorrhaphy	54.00
Conization	54.00
Cervix, amputation	54.00
Hysterectomy, vaginal or abdominal	162.00
Myomectomy	108.00
Uterine flexions, etc., correction	108.00
Oophorectomy	108.00
Ovariotomy	81.00
Salpingectomy, with or without oophorectomy or appendectomy	108.00

OPHTHALMOLOGY

Cataract, needling operation for	54.00
Cataract, operation for	108.00
Chalazion, operation for	10.80
Extensive, peripheral corneal ulcer, cauterization of	27.00
Extropion, operation for	54.00
Entropion, operation for	54.00
Enucleation of eye	81.00
Foreign body, removal from conjunctive (dissection)	16.20
Foreign body, removal from conjunctive (magnet)	10.80
Foreign body, removal from cornea (dissection)	27.00
Foreign body, removal from cornea (magnet)	21.60
Foreign body, removal from eyeball (deep), with or without magnet	108.00
Curettage of lids for trachoma	10.80
Hordeolum, operation for	5.40
Iridectomy	81.00
Lacrymal duct, dilatation of	5.40
Lacrymal sac, excision of	64.80
Pterygium, operation for	43.20
Ptosis, skin and tarsal resection, operation	81.00
Strabismus, operation for	86.40

ORTHOPEDIC

Arthroplasty, major joint	162.00
Bone graft, long bone	162.00
Bone plate, removal of	37.80
Cartilage of condyle of femur, removal of	108.00
Semilunar cartilage, removal from joint	81.00
Club foot, operation for	81.00
Coccyx, excision of	81.00
Hallux valgus, operation for	54.00
Hallux valgus, bilateral, operation for	81.00
Hammer toe, operation for	54.00
Osteomyelitis, long bones radicle operation	81.00
Sequestrum, removal of (deep)	54.00
Sequestrum, removal of (superficial)	16.20
Tenorrhaphy, one	37.80
Tenorrhaphy, each additional	16.20
Tenotomy	54.00
Torticollis, operation for	81.00

OTOLOGY

Mastoid, acute, operation for	108.00
Mastoid, radical, operation for	135.00
Ossiculectomy	108.00
Paracentesis	10.80
Polypus, removal of	27.00
Lateral sinus, drainage	162.00

PROCTOLOGY

Anal fissure, operation for	27.00
Carcinoma of rectum, excision of	162.00
Fecal fistula, abdominal, operation for	81.00
Fistula, rectovaginal, operation for	108.00
Fistula, urethral, operation for	64.80
Fistula, vesico-vaginal, operation for	108.00
Fistula-in-ano, operation for	54.00
Hemorrhoidectomy	67.50
Stricture of rectum, operation for	75.60
Whitehead's Operation	81.00

THORACIC SURGERY

Bronchoscopy	54.00
Bronchoscopy and biopsy or removal of foreign body	81.00
Thoracoscopy	54.00
Thoracotomy, incision and drainage, including rib resection	108.00
Subphrenic abscess	129.60
Apicolysis	108.00
Lobectomy	162.00
Oleothorax	54.00
Paracentesis of thorax, diagnostic	5.40
Phrenic nerve operation	54.00
Pneumolysis, extra or intrapleural	108.00
Pneumonectomy	162.00
Pneumonotomym cautery	108.00
Pneumoperitoneum, first induction	16.20
Pneumoperitoneum, refills	10.80
Artificial pneumothorax, first induction	27.00
Artificial pneumothorax, refills	10.80
Scaleniotomy	54.00
Thoracotomy, without rib resection	43.20
Thoracoplasty, each stage	135.00

SURGICAL CARE OF TRAUMATIC WOUNDS

Incised, minor procedure (office type)	6.50
Lacerated	10.80
Punctured	6.50

UROLOGY

Genito-urinary examination with cystoscopy	27.00
Genito-urinary examination with retrograde pyelogram	37.80
Prostatic abscess, incision and drainage	81.00
Circumcision (infant)	10.80
Circumcision (adult)	21.60
Cystotomy, suprapubic	81.00
Epididymectomy	81.00
Hydrocele, aspiration of	5.40
Hydrocele, operation for	54.00
Nephrectomy or Nephrotomy	162.00
Nephropexy	135.00
Orchidectomy	54.00
Prostatectomy, perineal	162.00
Prostatectomy, suprapubic (one or two stages)	162.00
Prostatic resection, transurethral	108.00
Ureteral stone, removal of	135.00
Urethral stricture, dilation of	37.80
Urethrotomy, external	81.00
Urethrotomy, internal	54.00
Varicocele, operation for	54.00

SPECIALIST'S FEES

Office Visit (routine treatment and advice)	
Psychotherapeutic conference	7.55
Psychometric testing	8.65
Intravenous sodium amytal	10.80
Electro-encephalography	21.60
Electro-shock treatment	16.20
Ophthalmological	5.40
Nose and throat	5.40
Ear	5.40
Dermatological	5.40
Orthopedic	5.40
Neurological	5.40
Genito-urinary	5.40
Surgical	5.40

X-RAY

Abdomen, flat plate	10.80
Ankle joint, ant.-post. and lat. views	9.70
Arm, humerus, ant.-post. and lat. views	10.80
Bladder, with injection, ant.-post. and lat. views	16.20
Chest, survey film	8.10
Chest, for pulmonary, cardiac, or rib fracture, diagnosis, stereo	16.20
Chest, fluoroscopic	5.40
Colon, by barium enema	21.60
Clavicle, ant.-post and lat. views	9.70
Elbow, ant.-post and lat. views	9.70
Encephalography	16.20
Encephalography, including preliminary skull	32.40
Esophagus only	16.20
Finger	5.40
Fistulae, contrast study	16.20
Feet, ant.-post. and lat. views	9.70
Forearm, radius and ulna, ant.-post. and lat. views	10.80
Foreign body in eye, location of (fragment charted in three planes and its dimensions ascertained by method of Sweet or equivalent)	27.00
Gallbladder, Graham technic	27.00
Gallbladder, G. I., barium enema	77.75
Gastro-intestinal tract, complete x-ray study including fluoroscopy	43.20
Gastro-intestinal tract by barium meal and enema	54.00
Hand, ant.-post. and lat. views	9.70
Heart, single teleoroentgenogram	14.05
Hip joint, ant.-post. and lat. views	12.95
Kidneys, right and left for comparison	14.05
Kidney, ureter, and bladder	14.05
Knee joint, ant.-post. and lat. views	9.70
Leg, tibia and fibula, ant.-post. and lat. views	9.70
Lipoidal injection for bronchiectases, etc. (including roentgen)	27.00
Mammary gland study	17.30
Mandibles, each	11.90
Mastoids, regular	16.20
Mastoids, including petrous pyramids	16.20
Maxilla and facial bones	14.05
Myelography	24.05
Neck for soft tissue	12.95
Nose	11.90
Optic foramina	16.20
Pelvis, ant.-post. and lat. views	14.05
Pregnancy, with measurements	21.60
Pregnancy, without measurements	13.50
Pyelography, intravenous	28.90
Pyelography, retrograde	20.00
Sella Turcica	13.50
Semi-lunar cartilage, both knees	17.30
Shoulder girdle	12.95
Sialography, without medium	14.05
Sinuses, paranasal	13.50
Skull	20.50
Smith-Peterson nail	34.55
Spine, cervical ant.-post. and lat. views	15.10
Spine, dorsal	15.10
Spine, lumbar-sacral with coccyx	17.30
Spine, entire	45.90
Stomach and duodenum only	30.80
Stomach, duodenum, and gallbladder (dye)	45.90
Teeth, single	2.15
Teeth, complete (perispical examination)	16.20
Thigh, femur, ant.-post. and lat. views	11.90
Thorax, ribs	13.50
Toe	5.40
Urethro-cystography	16.20
Ventriculography	22.70
Ventriculography, including preliminary skull	35.65
Wrist	9.70

FLUOROSCOPIC & GENERAL

Reduction of fractures	5.40
Foreign body detection	5.40
Foreign bodies in esophagus or respiratory tract	10.80
Portable examination in hospital—add	5.40
Fluoroscopic, chest or abdomen	5.40

INTERPRETATION OF ROENTGENOGRAMS

Bones and joints, plain ant.-post. and lat.	5.40
Chest for pulmonary diagnosis, plain or stereo	5.40
Gastrointestinal series	5.40
Genito-urinary tract	5.40
Kidney films	5.40
Skull, following ventriculography or encephalography	5.40

WHEN THE CONVALESCENT NEEDS A "LIFT"

. . . because of lowered hemoglobin

Avoiding gastro-intestinal symptoms and upsets is a major consideration when hematinic therapy is indicated for the convalescent patient.

In simple hemoglobin deficiency due to lack of dietary iron, or in hypochromic anemia from other causes, Ovoferrin is an effective hematinic. For Ovoferrin is colloidal iron...iron that is in easily assimilable form, readily absorbed without disturbing side-effects. *No irritation, no constipating action, no dehydration in the intestine.* Ovoferrin stimulates the appetite and raises hemoglobin values of the patient.

HOW OVOFERRIN ACTS IN THE BODY

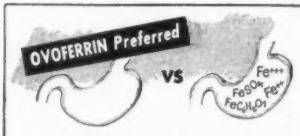
In the mouth . . . Pleasant and palatable, Ovoferrin is almost tasteless. Doesn't stain teeth or destroy tooth enamel.

In the stomach . . . Ovoferrin is stable, non-irritating. Non-ionizable, its colloidal structure remains practically unchanged by gastric juices, passes on ready for further assimilation.

In the intestine . . . Entering here in colloidal form, Ovoferrin iron is readily absorbed, utilized. A stable hydrous oxide that has neither dehydrating nor astringent action. No distressing side-effects, no constipation.

In hypochromic anemia that often accompanies pregnancy and lactation, adolescence and puberty, old age and debility states, Ovoferrin is a hematinic of value prescribed by physicians for many years. Pleasant to take, almost tasteless.

Available in drugstores in 11 oz. bottles. Dosage: one tablespoonful in milk or water at mealtime and bedtime.



Colloidal Iron vs. Ionizable Iron

Ovoferrin is colloidal iron protein. Non-ionizing, non-irritating. Easily assimilable.

Iron Salts that ionize may irritate, dehydrate, constipate the patient.

OVOFERRIN

COLLOIDAL ASSIMILABLE IRON

MADE BY A. C. BARNES CO., NEW BRUNSWICK, N. J.

Positions Wanted by Physician-Veterans

Any physician returning to civil life from the armed services or from a war agency may insert *free* in MEDICAL ECONOMICS (circulation: more than 100,000) a position-wanted ad of up to 24 words. The following data, which will be kept confidential, must accompany ad copy: name, address, rank or position, date. Copy must reach MEDICAL ECONOMICS before the 5th of the month preceding publication. Address: Veterans' Editor, Medical Economics, Inc., Rutherford, N.J.

DERMATOLOGIST, diplomate American board, seeks group association, partnership, full-time employment, or other suitable connection; now in New York. Box 1578.

GENERAL PRACTICE wanted in association with another physician; six-years' general practice; interested in obstetrics, pediatrics; licensed Illinois, Missouri, Wisconsin; now in Illinois. Box 1517.

GENERAL PRACTICE wanted in association with another physician or group; wife and child to accompany returned captain; now in New York. Box 1581.

GENERAL PRACTICE location wanted by colored physician; three years' hospital experience; now on terminal leave in Missouri. Box 1574.

GENERAL PRACTICE location wanted in good-size Illinois city; 31; three years' general practice; now in Illinois. Box 1561.

GENERAL PRACTICE location wanted, New York or New Jersey; consider assistantship or eventual partnership or purchase of practice; now in New York. Box 1576.

GENERAL SURGERY; fellowship, residency, or assistantship desired; now in Illinois. Box 1579.

INTERNAL MEDICINE or general practice assistantship wanted; Illinois preferred; now in Illinois. Box 1580.

OBS.-GYNECOLOGIST, 31, awaiting discharge, eligible for certification, seeks assistantship or association with certified gynecologist or with group; now in Pennsylvania. Box 1567.

OBS.-GYNECOLOGY; approved residency or assistant residency desired; or association with American board diplomate; 32; DNB; now in Massachusetts. Box 1562.

OBS.-GYNECOLOGY; assistant residency or association with diplomate desired by ambitious young veteran; now in New York. Box 1568.

OBS.-GYNECOLOGY; residency or associateship sought by approved-school graduate; 31; now in Minnesota. Box 1569.

PATHOLOGIST, laboratory director; diplomate American board; long experience in New York City; awaiting discharge in New York. Box 1573.

PEDIATRICIAN, American-board certified, seeks associateship with established man or clinic in Los Angeles; now in Wisconsin. Box 1560.

PEDIATRICIAN, certified, awaiting discharge, seeks association with group, clinic; consider individual practice in community needing specialist; prefer Texas or Southwest; now in Maryland. Box 1566.

RADIOLOGIST, board diplomate, 39, desires association with group or hospital in East, Midwest, or Northwest; former chief of service in large Army hospital; now in New York. Box 1577.

RADIOLOGIST, awaiting American board examinations, seeks position; experienced in private practice, hospital work; 3½ years chief of X-ray service, Army hospitals; now in New York. Box 1572.

SURGEON; FACS; 37; available for group, industrial, or assistant's position; experienced general orthopedic and urological surgery; licensed in New York; will purchase private practice. Box 1564.

SURGERY, PROCTOLOGY; well-trained man, 50, seeks group appointment in Midwest, Northwest; now in Missouri. Box 1570.

UROLOGICAL residency desired for July 1946; four years' Army service, combined urology and venereal diseases; eight months' post-graduate urology training; now in New York. Box 1575.

WRITER seeks assignments from manufacturers or advertising agencies for writing or consultation; experienced; can furnish references; now in New York. Box 1565.

WRITER wants assignments for preparation of literature, ethical advertising, or articles or columns for lay press; experienced; now in Pennsylvania. Box 1563.

WHY

A METABOLIC TEST?

AS WELL AS U.S.P. ASSAY

The usual (chemical) method of assaying thyroid does not always assure a product of constant metabolic potency.[1,2] Therefore, a biological assay was developed to standardize the metabolic activity of Proloid. Thus, more uniform patient-response is possible. In addition, the U.S.P. assay method is used.

Why No Odor? Being more highly purified than ordinary desiccated thyroid, Proloid is odorless. Unwanted animal substances have been removed.

Dosage: Proloid is used wherever thyroid is indicated, in the same dosage as U.S.P. thyroid. In ¼, scored 1 and scored 5 grain tablets.

[1] Harrington, C. R.: "The Thyroid Gland," Oxford, 1933, p. 141.
[2] Meyer, A. E., and Wertz, A.: Endocrinology 24: 806, 1939.

PROLOID the improved thyroid

The Maltine Company NEW YORK 22

State Medicine

Study Shows No Big Need for State Medicine

To Louis I. Dublin, Ph.D., chief of the actuarial division of the Metropolitan Life Insurance Company, the American health picture looked reassuringly bright. While others were viewing our national health problems with alarm, he had probed through voluminous records and had come up with some illuminating facts:

¶ Though the cream of the nation's youth was in the armed forces and the average age of the civilian population was considerably higher than normal, the civilian death rate was gratifyingly low.

¶ The year 1945 had brought new lows in the death rates of pneumonia, tuberculosis, and appendicitis; maternal and infant mortality were down too.

¶ Cancer was statistically on the increase but this was explainable on two counts: (1) the aging of the population; and (2) wider recognition of the disease because of educational efforts.

The New York Times, which leans toward Federal compulsory sickness insurance, reported these and other facts assembled by Dr. Dublin. Then, the same week, it said editorially that while the AMA might be able to develop its national prepay plan, the U.S. cannot wait for "experimentation." It added: "The coverage must be comprehensive and the scope national."

Dr. James M. McCann, president of Massachusetts Medical Service, bluntly told the newspaper it was using a "choice political weapon, the creation of confusion." According to Dr. Dublin, he continued, "the health of the American people was maintained at a very high level in 1945; according to your editorial, we must make haste to change systems so that the health of the American people will be maintained at a very high level.

"Certainly, in view of Dr. Dublin's report and the consensus of other leading health authorities, the nation is sufficiently healthy to permit a little time to adjust in a democratic manner to changing social and scientific technics in the fields of medicine and the sciences."

Await Dewey Message on Insurance

Awaiting Governor Thomas E. Dewey's promised message on sickness insurance, the New York State legislature pigeon-holed a number of new bills to introduce compulsory prepayment systems into the state. One had been submitted under Democratic sponsorship, another by the state federation of labor. Still to come was a measure prom-

ised by the Republicans.

The Democratic proposal was another "little Wagner-Murray-Dingell bill." Providing comprehensive medical care and hospitalization, it would be financed by a payroll deduction of 3 per cent on salaries of up to $3,600 a year.

The federation of labor bill would impose a payroll levy of 0.5 per cent on employers and none on employes. It would pay cash benefits of from $15 to $21 a week for up to twenty-six weeks of illness and maternity benefits for six weeks.

Compromise Health Plan Draws Criticism

The irreconcilables in both camps were dissatisfied. The New York Academy of Medicine's Committee on Medicine and the Changing Order had made a statement on compulsory health insurance which damned President Truman's endorsement of compulsion but left the way open for "experimental" compulsory insurance at the state level*. Conservative physicians declared that a little compulsion was like a little pregnancy; zealots in the Wagner-Murray-Dingell camp insisted that the committee, despite its disavowals, was interested in maintaining the status quo.

The committee recommended:

¶ A thorough trial of voluntary, nonprofit prepayment plans in the provision of medical service for low-income families.

¶ Government support, prefera-

[*Continued on page* 108]

*The committee had not completed its final report, which it expects to issue some time this year, but said it felt impelled to issue an interim statement in view of President Truman's recommendations to Congress on social security.

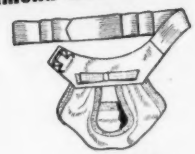
Which TYPE of suspensory do YOU recommend most often?

With Leg Straps

Most widely used style. Leg straps hold sack in proper position at all times, even if patient is very active. *Bauer & Black O.P.C.* No. 2 and No. 3.*

Without Leg Straps

Elastic pouch edge assures proper fit and position. *Bauer & Black Auto No. 16 & No. 19.*



Drawstring Type

Pouch adjustable to varying individual sizes or preferences. Extremely popular with many wearers. *Bauer & Black Model Atlas No. 9.*

You have 8 different suspensories for your prescription in the Bauer & Black selection—the three types shown above, each in a choice of prices. Available at all drug and surgical supply stores.

Learn WHY doctors who are familiar with construction details so often prescribe BAUER & BLACK O.P.C.* Suspensory!

Doctor! *Before you prescribe ANY suspensory, see our O.P.C.**

Just compare! Honestly, if you will ask your druggist to show you an O.P.C.* *and any* other make of suspensory, we are firmly convinced you, too, will recommend the O.P.C. to your patients. Won't you make a 60-second comparison . . . *soon?*

Seamless pouch, elastic knit for firmer support, greater comfort. No heavy, bulky joinings at any point. Elastic around the opening for added comfort.

Leg bands placed at exactly right points to assure full retention of scrotum, no matter what the patient's position.

Waistband—full elastic—ample stretch to permit removing without unbuckling. Affords greater comfort and convenience, longer wear, better fit. Free from any cumbersome pads or bulky stitching.

Quality tailoring—superb craftsmanship and exquisite needling—distinguish all Bauer & Black Elastic Supports. Finer materials, too. You'll recognize Bauer & Black superiority at a single glance.

First in Elastic Supports

*Reg. U.S. Pat. Off.

BAUER & BLACK

Division of The Kendall Company, 2500 South Dearborn Street, Chicago 16

an *exposé* of a basic defect in average milk diets

The *degree* and *extent* in which the milk diets of early infancy are *deficient* in certain B factors is not always fully appreciated.

"... the average breast-fed baby does not receive his requirement of thiamine ..."[1]

"Both human and cow's milk are poor sources of nicotinic acid ..."[2]

"The daily intake (of riboflavin) of the young infant fed only human milk is considerably lower than this estimate of requirement (0.5 mg.), even when the riboflavin content of milk is at its maximum."[1]

White's MULTI-BETA LIQUID

is formulated specifically to compensate for these inadequacies, supplying thiamine, riboflavin and nicotinic acid in amounts directly proportionate to their inadequacies, and, in addition, pyridoxine hydrochloride and calcium pantothenate.

FORMULA:

Each cc. (approx. 20 drops) contains:

THIAMINE HYDROCHLORIDE, U.S.P.	2.5 mg.
RIBOFLAVIN	500 micrograms
PYRIDOXINE HYDROCHLORIDE	150 micrograms
CALCIUM PANTOTHENATE	200 micrograms
NICOTINAMIDE	10 mg.

Non-alcoholic. Imparts no odor or taste. May be added to feeding formula or orange juice. Supplied in bottles (with droppers) of 10 cc., 25 cc. and 55 cc., and in 8-oz. dispensing bottles.

IN RESTRICTED ADULT DIETS—such as the Sippy treatment, Karell regime, and others based upon milk, White's Multi-Beta Liquid is a sound, economical supplement. Also of value in tube feeding and when difficulty in swallowing tablets or capsules is encountered.

1. Marriott, W. McK.: Infant Nutrition, revised by Jeans, Mosby, St. Louis, 3rd Edition, 1941.
2. Jeans, P. C.: The Feeding of Healthy Infants and Children, J. A. M. A., *120*: 913, 1942.

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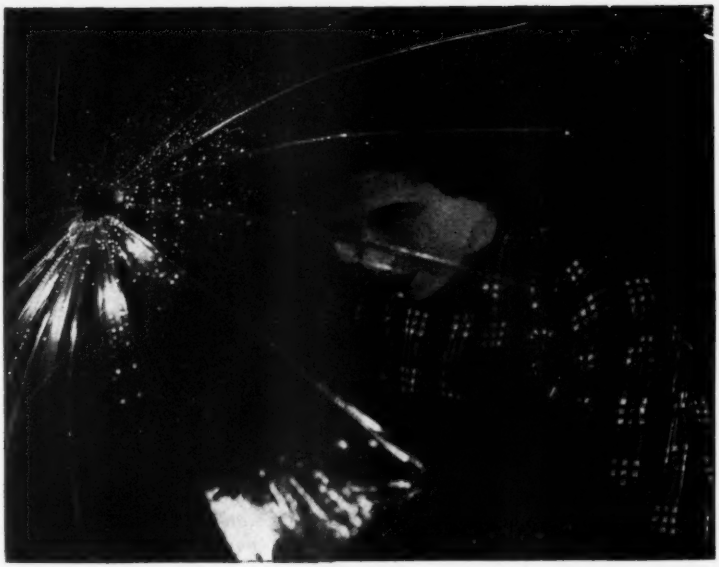
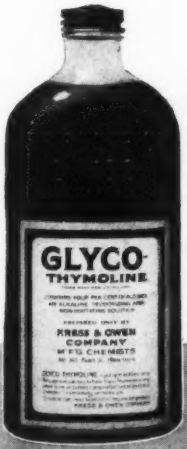




When unstable weather causes discomfort to the oral mucous membranes, Glyco-Thymoline will help to bring speedy, soothing relief from the congestion and inflammation, and aid in restoring normal conditions.

Samples sent on request

KRESS & OWEN COMPANY

361-363 Pearl Street New York 7, N.Y.

GLYCO-THYMOLINE
for Colds and Sore Throats

bly in the form of state or Federal grants-in-aid, where voluntary plans are unable to function satisfactorily because private resources are inadequate.

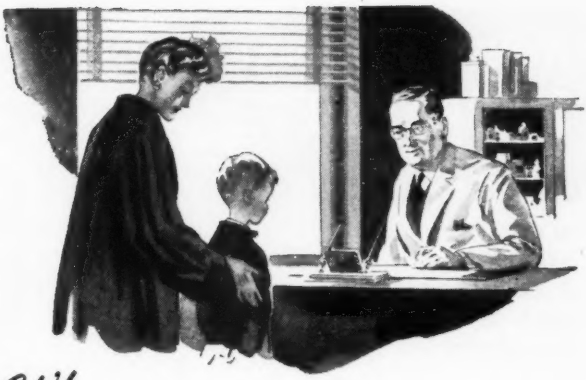
¶ "Careful experiments," at state and local levels, with compulsory government insurance, "so that we may have in the near future comparative experience with the relative values of voluntary and compulsory procedure."

¶ Gradual extension of group practice, "which promises far-reaching improvements in the organization of practitioners and specialists."

¶ Greater emphasis on preventive medicine.

"Any scheme of national compulsory medical insurance at this time would lead to most unfortunate results affecting the health of the nation and the science and practice of medicine," the committee asserted. "What is wanted is not an over-all national compulsory scheme but a variety of studies and experiments conducted by smaller units at local levels. It is far better to proceed in a somewhat slower but more orderly manner than to expose the nation to the risks, as yet unmeasurable, which immediate adoption of national compulsory insurance would entail."

The committee has spent three years on a comprehensive study of the distribution and adequacy of medical care. It is composed of representatives of medicine, labor, industry, law, social work, the clergy, and the public at large, and has met weekly to hear the opinions of invited experts. Contributing to the cost of its work have been the Commonwealth Fund, the Milbank Memorial Fund, and the Josiah Macy Jr. Foundation.



When

GROWTH DEMANDS AND APPETITE

Do Not Keep Step

During periods of rapid growth, the greatly augmented nutritional requirements may not be completely satisfied. Thus a state of undernutrition may be engendered which can produce permanent damage to the organism. Since appetite may not keep step with nutritional need during these periods, special measures must frequently be taken to prevent metabolic damage.

Ovaltine proves an excellent food supplement for this purpose. Children enjoy its delightful taste, and drink it with relish, without coaxing. Made with milk as directed, it helps supply the very nutrients required when growth needs must be met: complete protein, readily utilized carbohydrate, easily emulsified fat, essential vitamins, and minerals including generous amounts of iron, as indicated by the table of composition below.

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Ovaltine

Three daily servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	1.50 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.81 mg
CALCIUM	1.12 Gm.	VITAMIN C	39.6 mg.
PHOSPHORUS	0.939 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.75 mg.

*Based on average reported values for milk.

A *New* APPROACH TO MYOPATHIES

Basic Relief of

MYOSITIS
FIBROSITIS
FIBROMYOSITIS
AND KINDRED
CONDITIONS

A NEW RATIONALE, quite different from the previous approach with rubefacients and counterirritants, places Myopone therapy in a field by itself.

Formulated to the new concept that myopathies are etiologically of local metabolic origin, topically applied Myopone apparently supplies a deficiency in affected muscular tissue. Utilization of the special solvent-extracted wheat germ oil contained in Myopone puts into action not only essential vitamin E but also phospholipids and other therapeutically active factors*.

FORMULA: Solvent-extracted wheat germ oil in a special absorption base.

Topical application of Myopone Ointment relieves soreness, eases tension, reduces swelling and stiffness.

Available in 1 oz. and 1 lb. jars at ethical pharmacies.

SAMPLES AND LITERATURE ON REQUEST

*Ant. M., N. Y. State Jour. Med. Sept. 1, 1945

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MYOPONE
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A DRUG PRODUCTS COMPANY
Specialty

'This is What Gripes Me . . .'

Demobilized doctors voice criticisms of colleagues who stayed at home

Physicians mustered recently out of the armed forces tend to be resentful of the manner in which they have been welcomed back to civilian practice. This fact emerges from a national inquiry being conducted by MEDICAL ECONOMICS. Replies to a questionnaire sent to all physician-veterans reveal that many are "disgusted" by the attitude of their home-front colleagues; that some decry the lack of residencies, post-graduate courses, and hospital privileges; that some feel they have been let down by their medical societies; and that others gripe about what they regard as inadequacies in the G.I. Bill of Rights, unfair licensure laws, the shortage of office space, housing, and cars, and the inroads of chiropractic and osteopathy. A minority of the replies contain bouquets for the home front; most of them heave brickbats.

Statistically, the results (based on the first 2,000 replies received) seem to confirm the prediction made months ago by the editors of this publication that a majority of veterans would have to depend largely upon their own resources and initiative in re-establishing their practices. For example:

HOME-FRONT M.D.'S

To the question, "Have home-front physicians been a help, a hindrance, or neither?" veterans replied:

Neither	49.7%
A help	47.0
A hindrance	3.3

The comments of those who felt they had not been helped were more abrasive than the statistics. Typical remarks:

Pediatrician, Tennessee: "Doctors who stayed at home and 'cleaned up' seem to have no feeling of debt. They give you a big slap on the back, say, 'Nice job!'—then try to hold your old patients, even though the latter desire to come back to you."

G.P., Oregon: "My problem is getting back those patients who, in my absence, went to my neighborhood competitor. Flush after five years of no competition, he is planning to erect a new building across the street from me."

Surgeon, Massachusetts: "It gripes me to find refugee doctors employing unethical tactics. . . using political and social lay influence to obtain hospital-staff positions."

Internist, Kentucky: "Am practicing temporarily in a small town where the doctors seem to have the idea that physician-veterans should make all the country house calls."

G.P., Michigan: "All but two of

DARTHRONOL

IN THE *Systemic*

REHABILITATION OF CHRONIC ARTHRITICS

That chronic arthritis is a systemic disease of which the joint lesions are only one manifestation . . .

. . . is revealed by the frequent concurrence of many symptoms referable to systemic disturbances: loss of weight, anemia, neuritis, senile metabolic changes, gastro-intestinal affections, impairment of liver function, increased sedimentation rate, impaired carbohydrate metabolism, and early development of arteriosclerosis.

For the effective treatment of a systemic disease as complex as arthritis it is necessary to institute a complete program of systemic rehabilitation. Such a program must include optimal nutrition, physical and mental rest, supervised exercise, physical therapy, orthopedic measures, and all the essential vitamins in amounts sufficient to exert both nutritional and pharmacodynamic influences.

Darthronol merits inclusion in such a program of systemic rehabilitation. It supplies in a single capsule massive dosage of vitamin D in addition to adequate doses of the eight other essential vitamins. The need for greatly increased amounts of all the essential vitamins has been repeatedly demonstrated in arthritic patients.

Extensive bibliography on the role of these vitamins in the management of arthritics and the comprehensive brochure "Systemic Therapy in the Arthritides" will be sent on request.

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Remember Ry-Krisp

Ry-Krisp is indicated as bread in diets for people sensitive to eggs, wheat or milk because it contains only natural whole-grain rye, salt and water.

A crisp, unleavened bread containing the protein, minerals and B-Complex vitamins of whole-rye grain . . . light and airy in texture . . . with a delicious rye flavor . . . Ry-Krisp is a desirable every-meal bread for the whole family. The only bread of its kind available nationally.

FREE! REVISED RY-KRISP ALLERGY DIETS . . . *Tenth Edition*

For years Ry-Krisp Allergy Diets have received enthusiastic endorsements from doctors throughout the country. This year these diets have been revised—in accordance with your wishes—to more completely fit your needs.

Four diets: Egg-free, wheat-free, milk-free, and combined egg-wheat-milk-free. Printed on 8½x11" sheets in pads of 25 each. Diet sheets contain: (1) list of allowed foods, (2) list of forbidden foods, (3) guide for selecting a nutritionally adequate day's dietary, (4) special recipes. Free in quantities.

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Please send, no cost or obligation, material checked below.

- ☐ C2143 Samples of Revised Allergy Diets
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Offer limited to residents of Continental United States)

the home-front physicians with whom I have had dealings have been obstructive or uncooperative. One, in fact, has attempted to prevent me from opening an office next to his because he fears I may take some of his patients."

Surgeon, Texas: "Physicians who remained at home and inherited lucrative compensation work are keeping it—with no effort on the part of the insurance companies to find out whether we would like it back."

Radiologist, New York: "My friends, to whom I referred all my patients when I went into service, advised me to remain in the Army! One physician—in the same neighborhood with me for ten years—prevented me from renting the only available apartment in town. Luckily, I have found employment with a busy physician."

G.P., Indiana: "Have had numerous old patients come back to me, but none were *sent* back by physicians to whom I referred them when I went into the Army. Is that playing the game fairly?"

MEDICAL SOCIETIES

The response to the question, "Has your local medical society aided you, obstructed you, or done neither?" revealed even greater discontent. The statistics:

Neither	66.1%
Aided	33.2
Obstructed	0.7

M.D.-veterans, who may on occasion have overlooked the limitations of medical societies or reflected an unawareness of what the societies were doing, suggested that the danger of serious disunity in the profession was by no means remote. An Alabama surgeon asked: "Why not organize the medical veterans and give us something concrete—instead of the AMA?" Others,

Acne can be cleared up quickly

SAFE
EFFECTIVE
NON-MESSY
EASILY APPLIED
COLORLESS
NO DRESSING NEEDED

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On Prescription
at Druggists

Announcing

A NEW TREATMENT FOR ACNE VULGARIS

INTRADERM

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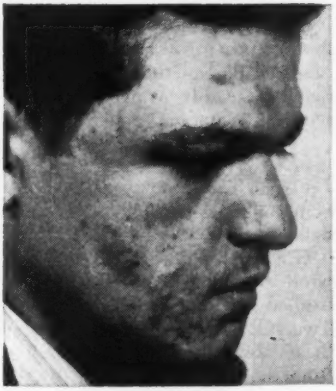
SKIN PENETRANT

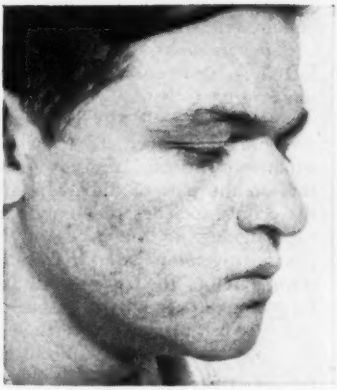
SULFUR SOLUTION

• Utilizing a new principle of skin penetration, Intraderm Skin Penetrant—Sulfur Solution gives the physician a simple, effective treatment for all types of acne.

Intraderm Sulfur achieves a high degree of saturation of the pilosebaceous apparatus with sulfur in its most effective form—soluble, highly active polysulfides.



Acne cystica, duration 3 years. Previous treatment: ultra-violet light, lotio alba. Picture after 1 week's treatment with Intraderm Sulfur.



Picture 18 weeks later, patient having remained well for 6 weeks, during which treatment was applied only occasionally.

(REPRODUCED FROM UNRETOUCHED PHOTOGRAPHS)

HOW INTRADERM SULFUR HEALS ACNE

● Intraderm Sulfur is one of a group of solutions developed over the last 5 years by Wallace Laboratories, Inc.

These solutions have a far greater capacity to effect deep skin saturation than has been exhibited by any agents now in use. They cause chosen drugs to pass down the hair follicles, through the sebaceous glands and the root sheaths out into the dermis. Intraderm Solutions also impregnate the top horny layers.

Intraderm Sulfur Solution was developed specifically for the treatment of acne. It contains sulfur and polysulfides in a mildly alkaline, skin-penetrating base.

Intraderm Sulfur is applied to affected areas as frequently as tolerated, usually once or twice daily until healing is complete. Its penetrating action delivers medication at site of infection below skin surface.

FIVE YEARS OF CLINICAL RESEARCH

● Intraderm Sulfur for the local treatment of acne is offered to physicians after 5 years of clinical research.

Carefully controlled experimental and clinical studies having established the effectiveness of the basic Intraderm Solution as a skin saturating agent, therapeutic trials with Intraderm Sulfur Solution were begun.

One of the groups studied consisted of a total of 130 of the most stubborn cases of acne comedo, papulosa, pustulosa, indurata, cystica and erythematosa. Most had been resistant to treatment with other local remedies, but responded promptly to Intraderm Sulfur, so that the results compared favorably with X-ray treatment. (*MacKee, Wachtel, Karp and Herrmann, Journal Investigative Dermatology, Oct., 1945.*)

Descriptive literature and sample on request.

WALLACE LABORATORIES, INC.

NEW BRUNSWICK, NEW JERSEY

though less bluntly rebellious, were equally critical:

G.P., Indiana: "The AMA neglected its service members during the emergency."

Internist, New York: "The most discouraging aspect of this whole situation is the utter lack of preparation on the part of the AMA and the county societies. The only ones campaigning for the needs of the physician-veteran are the radio commentators, the newspapers, and the columnists—many of whom do so for selfish reasons. Nevertheless, they are bringing to public attention our difficulties in finding offices, buying cars, and obtaining residencies and post-graduate courses. Where is the AMA?"

G.P., Massachusetts: "I have filed an application for admission to the local medical society, but this will not be acted upon for several months. Meanwhile, because I am not a member, I cannot get hospital privileges."

HOUSING

With the country in the midst of its worst housing crisis in a generation, it was hardly a surprise to find that doctors too were having trouble locating homes and office space (see MEDICAL ECONOMICS, February 1946). When asked, "Has finding professional office quarters been easy, difficult, or impossible?" veterans replied:

Difficult	52.3%
Easy	37.4
Impossible	10.3

POST-GRADUATE EDUCATION

A fourth question asked by MEDICAL ECONOMICS was this: "Are satisfactory post-graduate educational facilities readily available in your section?" Veterans replied:

Yes	54.9%
No	39.5
Don't know	5.6

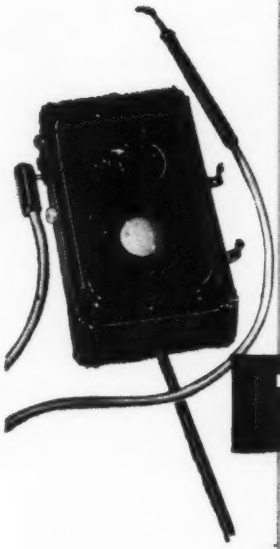
Some of the respondents went into detail:

G.P., New York: "Last August, I wrote six medical schools about refresher or specialization courses. Two still have not had the courtesy to acknowledge my letter. Replies from the others are identical: 'We are working on the problem but nothing is available at present for the discharged veteran.' So I've given up and applied for appointment to the Veterans Administration."

G.P., Indiana: "There seems to be a scarcity of refresher courses of the right type. Most helpful would be one-day-a-week ward rounds or bedside clinics at nearby large centers."

G.P., North Carolina: "As far as I have been able to determine, little or nothing has been done about post-graduate courses for veterans. Some schools (Duke, for example) schedule clinic sessions at which the veteran may sit in. But no special courses have been provided."

Other specific criticisms of the home-front, which add up to a discomfiting indictment, are quoted below: [*Continued on page* 120]



.."simplifies several procedures."
— Urologist

.."cervical coagulation results outstanding."
— Gynecologist

.."invaluable for rectal and sigmoid dessication."
— Proctologist

.."wonderful cosmetic results."
— Dermatologist

.."ideal technic for tonsil tabs and turbinates."
— E. E. N. T. Specialist

.."so many daily uses."
— General Practitioner

Versatility

The HYFRECATOR by BIRTCHER has more than 33 proven technics of electrodesiccation. How *many* more it is impossible to estimate, because thousands of general practitioners, E. E. N. & T. specialists, dermatologists, proctologists, gynecologists and urologists daily discover new uses for this versatile device.

Compact and exceptionally economical of time and effort, because its use entails no fore or after treatment, the HYFRECATOR enables the doctor to treat more patients with greater efficiency. $37.50 complete.

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Los Angeles 32.

10th ANNIVERSARY YEAR

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ADDRESS _____

CITY _____ ZONE _____ STATE _____

R-3-6

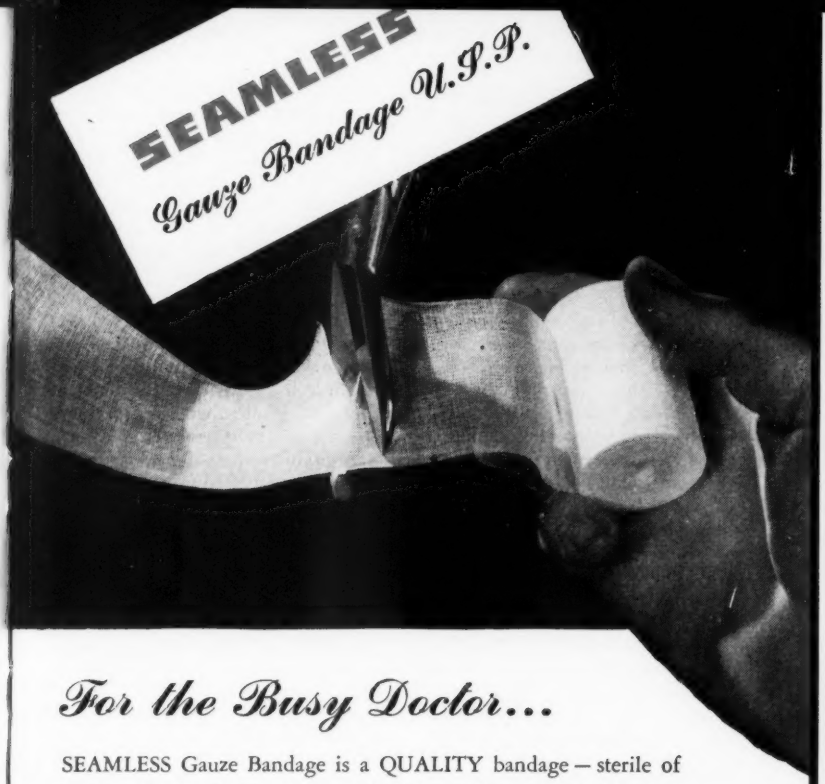
G.P., Illinois: "Have attempted to secure a residency. Some institutions frankly admit they are giving preference to their present internes—men who have been receiving Government assistance in their schooling, and haven't seen active duty. Others say that attempts to increase the number of residencies for veterans have been prevented by the Procurement and Assignment Service. Why?"

Resident in radiology, New York: "I was very fortunate. I was helped immeasurably by physician friends, and was taken on here immediately after discharge. Men who are now being released won't find it quite so easy. Hospitals are being quick to cut salaries and allowances now that more men are available. We are again in the 'coolie labor' class. Medicine still needs a Petrillo!"

Resident in obstetrics and gynecology, Ohio: "My training was interrupted by four years and three months in the armed forces. Now I am expected to support my family on $60 a month. What is being done to pay married residents a living wage? This hospital, a city institution, will not even furnish me with hospitalization should I become sick; it would charge me $7 a day—yet gives paupers free medical attention."

RESIDENCIES

Resident in urology, New York: "I had to come here from Georgia. Couldn't get an AMA-approved residency in my part of the country. Don't care for my present place, a city hospital, but it is all I can get along surgical lines. Obviously there were no plans to take care of the M.D. veteran; the atti-



For the Busy Doctor...

SEAMLESS Gauze Bandage is a QUALITY bandage – sterile of course–closely woven–44x36–of high tensile strength, bleached to a pure white, soft finish. The use of thread with the proper twist – plus mechanical "know how" – assures a non-ravel edge, without resorting to chemical treatment.

SEAMLESS Gauze Bandages help you make neat, long-lasting dressings quickly. When you specify SEAMLESS Surgical Dressings, you specify unfailing quality. Order them through your Surgical Supply Dealer.

SEAMLESS Gauze Bandages, U.S.P. . . . available in 1", 1½", 2", 3", and 4" widths, 10 yards long, inner-paper wrapped, individual re-closable container, 1 dozen to the carton.

SURGICAL DRESSINGS DIVISION

The SEAMLESS SR RUBBER Company

NEW HAVEN 3, CONN., U.S.A. FINEST QUALITY SINCE 1877

tude has been one of fine words but no action."

HOSPITAL CONNECTIONS

G.P., Massachusetts: "Am having trouble getting hospital privileges. Eventually I may get them; but it's *now* that I need the cooperation of the hospitals—not years from now."

G.P.-surgeon, New York: "In some hospitals, staff promotions were given to our juniors while we were away, leaving no place for us. Are such men to be rewarded for staying home, and are we to be penalized for going into the Army? Surely some thought should be given to this problem and some adjustments made."

Internist, Missouri: "Biggest headache is the shortage of hospital beds and the tendency to give the available ones to doctors who did not leave their practices."

G.P.-surgeon, Nebraska: "My problem has been the 'closed staff,' which makes it difficult for new men to gain a foothold. Personally, I have solved it by resigning myself to repeated postponements."

LICENSURE

G.P., Maine: "I have an opportunity to practice with a group but cannot take it because New York will not endorse my license. My family expenses make it economically impossible to wait and take state board exams."

Surgery resident, New York: "Discharged medical officers who have been graduated from approved medical schools should not be obliged to take the usual state board examination. Such men should be licensed immediately. I was in the Army five years, was prevented from obtaining a license by entry into service, and am still unlicensed."

G.P., Iowa: "After driving about 2,000 miles to obtain grades, signatures, etc., from the Missouri board and to deliver them in person to the Des Moines authorities, I have waited over a month without hearing a word—despite the fact that the grades were exceptional and the secretary promised to push through my request for reciprocity."

Gynecologist, New Mexico: "Before my Army service, I practiced eleven years in Ohio and was also licensed in Michigan. Discharged with spinal arthritis, I had to change climate. It's a slow process trying to get a license here. It's also impossible to get office space, and not easy to establish hospital connections."

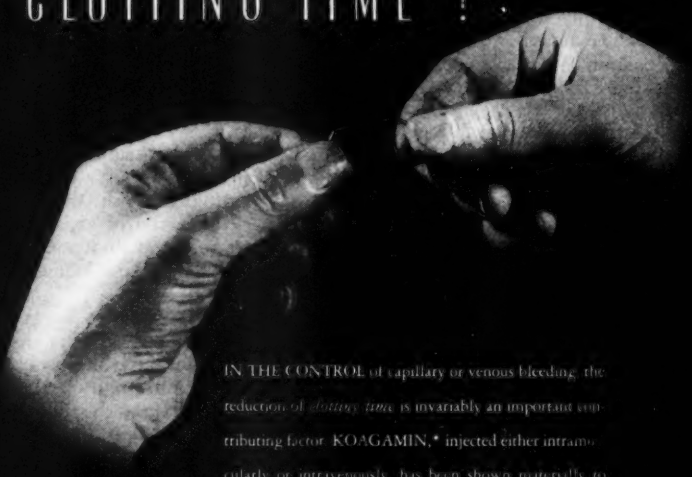
G.P., New York: "It was my intention to settle in some physician-shortage area in the Rocky Mountain states, but reciprocity difficulties forced me to abandon the idea."

Surgeon, Maine: "National legislation should be passed immediately giving full reciprocity in all states to ex-service doctors."

G. I. BILL

G.P., Michigan: "The G.I. Bill does not provide tuition for postgraduate work during terminal leave. This is the logical time for

What's the CLOTTING TIME ?



IN THE CONTROL of capillary or venous bleeding, the reduction of *clotting time* is invariably an important contributing factor. KOAGAMIN,* injected either intramuscularly or intravenously, has been shown materially to reduce the clotting time of the blood.

In hemorrhagic diseases, abnormal bleedings, blood disorders and in surgery *pre-, peri-, post-operatively* KOAGAMIN should be a first consideration at all times . . . a wise precaution . . . a definite adjunct to the control of bleeding.

Abundant clinical reports of its successful use testify not only to its value as a dependable hemostatic agent but add impressive evidence as to its non-toxicity.

Chatham

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such study; but tuition must be paid in advance, and there is no legal provision for Government assistance until later. Hence, the veteran is delayed in returning to his profession unless he can finance such study himself. In my case, it cost me $125 for about five weeks' tuition."

G.P., Pennsylvania: "I have been informed that I am ineligible for a G.I. loan for paying equipment bills because I went ahead and made initial deposits on needed items. I had not been told that an appraisal by the Veterans Administration was required before ordering the items."

Surgeon, New York: "The G.I. set-up on post-graduate courses is bad. Not all of us can devote three months or so to the longer courses. On the short, intensive ones (10 days to a month), the Government pro-rates the allowance. Thus, on a two-week course, for which tuition costs $90, the total Government allowance, including maintenance, comes only to about $67.50. The veteran must pay the balance himself. I think some organized group should endeavor to get a re-ruling on this phase of the G.I. Bill."

Resident in chest surgery, Michigan: "I find that I must depend on reserve savings to finish. Why can't the Government be of assistance—as it was to medical students? Most of us have families, and living costs are high."

One physician put his finger on the sorest point of all: "The situation is critical for those already out," he said. "I hate to think of what it will be for the thousands still awaiting demobilization."

FITTING ESTROGENIC THERAPY TO THE CASE

"Premarin" Liquid, No. 869 . . . for greater flexibility of dosage and to provide a graduated estrogenic intake where required. Each teaspoonful is the equivalent, in potency, of one "Premarin" Half-Strength Tablet, No. 867.

"Premarin" Tablet, No. 866 . . . for severe estrogenic deficiencies requiring a highly potent yet essentially safe and well-tolerated preparation. Full therapeutic doses of "Premarin" induce a prompt response as judged by vaginal smears and by relief of subjective symptoms.

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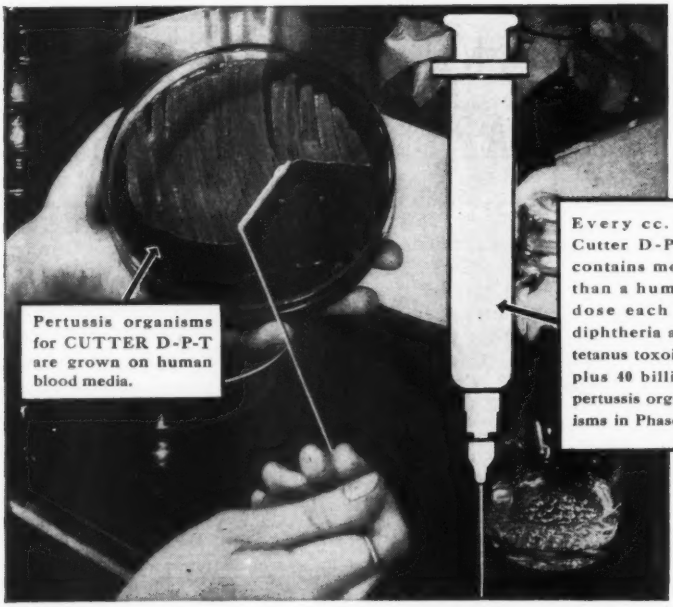

WHICH combined vaccine will you use on your patients?

The following may be helpful in finding a satisfactory answer:

It has been established by most investigators that 100 billion organisms in Phase I is the optimum pertussis dosage for children under three. *Pertussis organisms for Cutter D-P-T, grown on human blood media, are guaranteed to be in Phase I, with 40 billion organisms per cc.*

While adequate protection must be provided against all three diseases, injections must not be so large as to cause undue pain and tissue distention. *Purified toxoids and extremely high pertussis count yield a vaccine so concentrated that your dosage schedule is only 0.5 cc., 1 cc., 1 cc.*

Sterile abscesses, often a danger when pertussis vaccine is mixed with alum toxoids, are to be avoided. *Cutter D-P-T (Alhydrox) is aluminum hydroxide adsorbed, determined by Miller to be more potent than alum precipitated vaccines. Moreover, persistent nodules and sterile abscesses are eliminated almost entirely, and there is less pain on injection because of a more normal pH.*

May we suggest that you use Cutter D-P-T, proving its advantages to your satisfaction? Cutter Laboratories, Berkeley, Calif.; Chicago, New York.

Leading pediatricians specify CUTTER D-P-T

CUTTER
Fine Biologicals and Pharmaceutical Specialties

The Veteran

Society Status

"When I return to civil life," muses the medical officer, "will I be remembered as an individual by my county and state societies—or will I feel like a stranger?" That depends, says the New York State Medical Society. "Were you ever really known?" it asks. "You probably paid your dues regularly. But how often, at meetings, have you discussed matters from the floor? On how many committees and for how long have you served? Have you really given your societies the opportunity to know you, not only as a dues-paying member, but as a member with ideas, a voice, a personality? If you have done these things it is safe to say that you are remembered, wherever you are."

Red Cross Gives Plasma to V.A. Hospitals

The American Red Cross has made available to the Veterans Administration 125,000 units of blood plasma, V.A. officials have announced. They estimate that this bank of blood plasma for the 97 V.A. hospitals will last for approximately four years.

V.A. officials say the Red Cross was pleased to make the allocation from the reserve blood plasma turned back by the Army and Navy after the cessation of hostilities because veterans could thus obtain plasma which was originally contributed for use of the services to which they belonged.

Allotments will be made to V.A. hospitals for their immediate needs and the remainder will be stored in V.A. warehouses at Perry Point, Md., and Hines, Ill. The plasma will be distributed to the hospitals from these two central locations.

USPHS Called Unfair

He became a medical officer in the U.S. Public Health Service to serve in time of war, but now he is trapped in civilian work for the same agency, with no immediate prospect of release, complains an anonymous physician.

"If you are haunted by the threat of state medicine in the future, here is state medicine today," he told the Wayne County (Mich.) Medical Society. "If you fear for your own skins, consider your colleagues who have already lost their voice and the ability to fight for their rights."

Though thousands of physicians had been let out of the Army and Navy by the end of 1945, he asserted, not a single medical officer had been demobilized on points

from the Public Health Service, although the work was civilian in nature and had no connection with the war or military personnel.

'Share the Office' Plan Pushed by Society

As part of an intensive effort to obtain office space for demobilized physicians in the metropolitan area, the New York County Medical Society has been making a survey of its members to determine doubling-up possibilities. In its weekly bulletin, the society publishes this form:

"If you are willing to share your office with a returning medical veteran, please fill out this form and return it to Veterans' Service, New York Medicine.

"I am willing to share my office with a returning veteran.

"Office address ..... Tel. No. ..... Private House ( ) Ground Fl. Apt. ( ) Office Bldg. ( ) No. of Rooms...

"My specialty is .....I desire a physician whose specialty is .....Office hours will be available: .....A.M. .....P.M.

"I have the following employes whose services I would be willing to share .....

"I have the following apparatus which I would be willing to share .....

"I have telephone service which I would be willing to share ( ).

"I do *not* wish to share employes ( ); apparatus ( ); telephone service ( ).

"I desire $..... per month for rental, light, heat, and services listed above.

.....M.D."

STOPS HEMORRHOIDAL PAINS

. . . WITHIN 5 MINUTES

FOR the relief of the inflammatory rectal conditions, RECTAL MEDICONE meets these objectives:

1. ANESTHESIA OF THE EXPOSED NERVES
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3. DECONGESTION OF THE VARICOSITIES

Many thousands of physicians during the past ten years have employed RECTAL MEDICONE to relieve pain, control bleeding and reduce congestion in rectal conditions where surgery is not indicated, also in pre-surgical and post-operative treatment.

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RECTAL MEDICONE

Pierre and Marie Curie, physicists and chemists, whose brilliant work on radioactivity lead to their discovery of polonium and radium, for which they were awarded 1903 Nobel prize for physics.

FORWARD STEPS IN SCIENCE

As the discovery of radium by Pierre and Marie Curie was one of the great forward steps in modern science, so SKLAR'S adaptation of Stainless Steel to the highly specialized field of surgical instrument making represents a significant forward step in the practice of surgery.

SKLAR research evolved the alloys best suited to produce Stainless Steel instruments. SKLAR craftsmanship . . . much of it derived from close association with leading surgeons in the making and designing of fine precision instruments . . . developed the manufacturing techniques essential to superlative production standards. The resulting instruments are strong, resilient, well balanced and always dependable.

Today, J. SKLAR MANUFACTURING COMPANY makes the greatest variety of stainless steel instruments ever made by a single manufacturer. SKLAR *products are available through accredited surgical supply distributors.*

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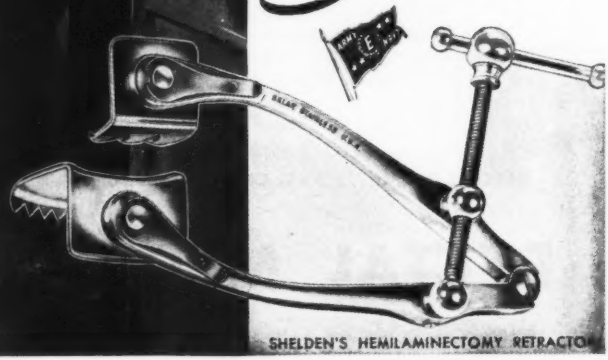

SHELDEN'S HEMILAMINECTOMY RETRACTOR

Post-Graduate Courses and Residencies

[*Continued from page* 57]

357, 360, 362, 363, 364, 368, 369, 372, 373, 374, 375, 376, 391, 396, 398, 401, 402, 403, 409, 413, 416, 418, 423, 425, 426, 427, 428, 430, 431, 432, 435, 436, 443, 459, 471, 481, 483, 484, 485, 487, 489, 491, 493, 496, 501, 502, 506, 511, 514, 516, 522, 524, 525, 526, 527, 529, 531, 532, 534, 535, 537, 541, 542, 547, 548, 549, 550, 552, 555, 556, 558, 559, 561, 563, 564, 576, 578, 580, 581, 587, 594, 602, 603, 608, 609, 611, 613, 616, 618, 619, 620, 622, 623, 625, 626, 630, 631, 632, 633, 634, 635, 640, 641, 642, 643, 644, 647, 649, 653, 654, 656, 657, 660, 663, 665, 669, 671, 682, 683, 684, 686, 687, 690, 691, 693, 694, 696, 699, 703, 705, 706, 708, 710, 711, 712, 713, 716, 717, 726, 733, 739, 740, 742, 743, 744, 747, 752, 754, 755, 758, 760, 761, 762, 763, 764, 767, 770, 779, 783, 793, 794, 798, 799, 801, 804, 810.

MALIGNANT DISEASES

Residencies: 199, 215, 320, 322, 346, 350, 373, 422, 459, 479, 503, 511, 546, 551, 602, 677, 689.

MIXED

Residencies: 79, 83, 84, 86, 87, 88, 90, 109, 116, 134, 136, 139, 140, 149, 151, 152, 186, 196, 197, 198, 243, 246, 248, 256, 260, 269, 272, 301, 318, 328, 331, 334, 345, 367, 370, 382, 386, 388, 392, 393, 394, 395, 405, 406, 421, 444, 448, 449, 474, 488, 507, 518, 523, 584, 595, 601, 604, 605, 610, 628, 629, 636, 645, 741, 746, 750, 753, 765, 766, 768, 771, 772, 773, 780, 789, 790, 791, 796, 797, 807.

NEUROLOGY, PSYCHIATRY

Post-graduate courses: 3, 5, 6, 12, 15, 16, 17, 19, 20, 22, 29, 37, 39, 40, 41, 42, 45, 47, 54, 70, 73, 75.

Residencies (neurology): 102, 175, 177, 225, 228, 262, 273, 282, 307, 320, 355, 364, 373, 401, 426, 481, 489, 525, 526, 534, 541, 547, 548, 549, 550, 552, 561, 602, 619, 686, 690, 703.

Residencies (psychiatry): 91, 95, 102, 123, 125, 130, 131, 137, 143, 148, 154, 158, 162, 164, 167, 175, 180, 204, 207, 212, 215, 225, 228, 233, 238, 241, 250, 253, 257, 261, 265, 268, 289, 302, 303, 304, 310, 311, 320, 330, 332, 333, 335, 337, 338, 339, 344, 348, 349, 354, 355, 360, 364, 373, 379, 385, 387, 389, 396, 398, 401, 407, 411, 413, 420, 423, 424, 426, 433, 437, 439, 441, 442, 446, 456, 461, 469, 471, 476, 477, 482, 498, 501, 504, 510, 517, 519, 520, 526, 545, 555, 560, 567, 570, 572, 573, 574, 579, 581, 588, 593, 594, 595, 598, 599, 602, 619, 624, 625, 638, 646, 652, 664, 670, 674, 676, 681, 688, 695, 696, 698, 703, 713, 715, 718, 721, 722, 723, 751, 752, 763, 770, 776, 777, 784, 798, 802, 808, 810.

NEUROSURGERY

Post-graduate courses: 20, 73.

Residencies: 102, 120, 131, 153, 203, 212, 219, 220, 225, 228, 289, 307, 317, 320, 364, 398, 401, 423, 471, 487, 489, 497, 526, 561, 581, 619, 626, 642, 868, 703, 743, 763, 770.

NUTRITION

Post-graduate courses: 19, 20, 62, 75.

OBSTETRICS, GYNECOLOGY

Post-graduate courses: 1, 8, 13, 16, 17, 18, 19, 20, 22, 25, 31, 32, 40, 42, 49, 53, 56, 58, 61, 64, 68, 70, 73, 75, 78.

Residencies: 81, 85, 102, 106, 111, 119, 127, 128, 130, 131, 132, 142, 160, 161, 162, 172, 174, 175, 176, 179, 181, 188, 192, 201, 202, 207, 208, 209, 213, 214, 215, 216, 219, 220, 221, 222, 223, 224, 225, 226, 228, 229, 230, 236, 242, 252, 253, 254, 262, 264, 266, 271, 273, 276, 282, 286, 289, 290, 291, 292, 294, 295, 298, 299, 307, 309, 312, 314, 321, 326, 355, 360, 361, 362, 363, 364, 365, 366, 368, 369, 372, 391, 396, 397, 398, 401, 402, 403, 413, 426, 427, 433, 434, 435, 436, 443, 445, 453, 459, 460, 471, 472, 478, 481, 484, 485, 487, 489, 491, 492, 493, 495, 496, 499, 501, 502, 514, 526, 528, 531, 532, 533, 537, 541, 542, 543, 547, 549, 550, 552, 554, 555, 556, 558, 559, 561, 562, 564, 565, 569, 581, 586, 589, 600, 602, 609, 613, 616, 619, 625, 627, 630, 633, 635, 641, 642, 644, 647, 648, 649, 657, 663, 671, 683, 684, 685, 686, 687, 690, 693, 694, 696, 703, 705, 708, 711, 713, 726, 728, 733, 739, 740, 743, 744, 747, 752, 754, 756, 757, 763, 770, 781, 786, 794, 798, 801.

OPHTHALMOLOGY, OTOLARYNGOLOGY

Post-graduate courses: 14, 16, 17, 18, 19, 20, 22, 25, 40, 52, 59, 75.

Residencies: 100, 102, 106, 118, 119, 122, 128, 130, 131, 142, 162, 173, 175, 188, 207, 210, 214, 215, 219, 220, 221, 222, 225, 228, 229, 252, 253, 262, 264, 271, 273, 274, 276, 283, 289, 299, 306, 307, 317, 319, 352, 355, 360, 362, 363, 364, 371, 373, 396, 398, 401, 402, 403, 412, 413, 423, 426, 427, 433, 436, 459, 466, 467, 471, 480, 487, 489, 491, 496, 501, 514, 522, 526, 531, 534, 436, 537, 544, 547, 550, 552, 553, 558, 559, 561, 562, 563, 578, 581, 585, 590, 594, 602, 619, 625, 626, 633, 635, 641, 657, 663, 671, 683, 685, 686, 690, 696, 703, 704, 709, 710, 731, 734, 740, 743, 747, 752, 755, 763, 770, 774, 779, 798, 801.

ORTHOPEDIC SURGERY

Post-graduate courses: 15, 17, 20, 40, 64.

Residencies: 81, 100, 102, 103, 106, 119, 120, 128, 129, 131, 141, 162, 163, 168, 170, 174, 175, 193, 195, 205, 207, 215, 222, 225, 227, 228, 229, 252, 262, 266, 270, 271, 273, 279, 288, 289, 307, 313, 317, 320, 343, 355, 364, 401, 404, 413, 417, 436, 438, 440, 445, 459, 464, 468, 489, 491, 496, 501, 527, 538, 539, 547, 550, 557, 563, 581, 585, 597, 602, 619, 626, 630, 635, 649, 655, 656, 657, 658.

[Continued on page 134]

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USED EFFECTIVELY IN THE TREATMENT OF

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Desitin Ointment contains Cod-Liver Oil, Zinc Oxide, Petrolatum, Lanum and Talcum. The Cod-Liver Oil, subjected to a special treatment which produces *stabilization* of the Vitamins A and D and of the unsaturated fatty acids, forms the active constituent of the Desitin Preparations. The first among cod-liver oil products to possess unlimited keeping qualities, Desitin, in its various combinations, has rapidly gained prominence in all parts of the globe.

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OTOLOGY

Post-graduate courses: 17, 40.

OTORHINOLARYNGOLOGY

Post-graduate courses: 15, 16, 17, 18, 19, 20, 24, 26, 39, 40, 42, 52, 58, 59, 60.

PATHOLOGY

Post-graduate courses: 3, 8, 16, 17, 19, 20, 27, 40, 60, 62, 70, 75.

Residencies: 81, 99, 100, 101, 102, 104, 106, 111, 115, 121, 125, 128, 130, 131, 132, 135, 144, 153, 156, 159, 162, 171, 175, 176, 177, 178, 181, 188, 192, 194, 205, 207, 215, 216, 219, 220, 221, 222, 225, 228, 229, 234, 235, 239, 242, 252, 253, 254, 258, 259, 262, 264, 266, 271, 273, 276, 277, 278, 280, 282, 289, 295, 299, 305, 307, 309, 313, 320, 321, 322, 324, 341, 346, 353, 354, 355, 360, 363, 364, 368, 372, 373, 374, 390, 391, 401, 402, 409, 413, 415, 416, 417, 423, 426, 427, 433, 443, 445, 447, 450, 459, 465, 471, 473, 481, 484, 486, 487, 489, 491, 494, 496, 501, 502, 511, 514, 528, 529, 532, 534, 537, 541, 542, 547, 548, 549, 550, 552, 555, 559, 561, 562, 563, 564, 566, 568, 578, 580, 581, 582, 590, 591, 594, 602, 603, 609, 613, 618, 619, 625, 630, 633, 634, 635, 641, 642, 643, 650, 654, 657, 659, 661, 663, 665, 669, 671, 675, 682, 683, 684, 685, 686, 690, 691, 693, 694, 696, 699, 703, 706, 707, 708, 710, 711, 712, 713, 714, 716, 724, 733, 735, 740, 743, 744, 747, 755, 762, 770, 681, 785, 788, 798, 799, 801, 804, 809, 810.

PEDIATRICS

Post-graduate courses: 17, 18, 19, 20, 22, 31, 39, 40, 48, 49, 52, 58, 59, 61, 64, 70, 73.

Residencies: 80, 81, 82, 93, 97, 100, 102, 106, 110, 119, 127, 128, 130, 131, 141, 144, 161, 162, 171, 174, 175, 188, 189, 192, 203, 207, 214, 215, 220, 221, 222, 225, 226, 228, 236, 252, 253, 262, 264, 271, 273, 276, 282, 289, 298, 299, 307, 308, 313, 320, 355, 359, 364, 391, 396, 398, 401, 412, 413, 426, 432, 433, 436, 459, 471, 484, 487, 489, 491, 493, 499, 501, 514, 526, 531, 537, 541, 542, 547, 549, 550, 552, 555, 559, 561, 563, 564, 576, 581, 585, 589, 594, 600, 602, 603, 607, 609, 611, 612, 617, 619, 635, 637, 657, 663, 678, 679, 680, 684, 686, 690, 691, 696, 700, 703, 707, 726, 730, 733, 739, 743, 745, 752, 755, 761, 763, 770, 778, 798, 800, 801.

PHARMACOLOGY

Post-graduate courses: 19, 20, 62, 75.

PHYSICAL MEDICINE

Post-graduate courses: 42, 70, 73.
Residencies: 130, 215, 219, 401.

PHYSIOLOGICAL CHEMISTRY

Post-graduate courses: 75.

PHYSIOLOGY

Post-graduate courses: 16, 17, 20, 27, 62.

PLASTIC SURGERY

Residencies: 401, 489, 561, 683.

POLIOMYELITIS

Post-graduate courses: 23, 60.

PROCTOLOGY

Post-graduate courses: 15, 31, 39, 40, 42, 52, 75.

PUBLIC HEALTH

Post-graduate courses: 2, 20, 22, 25, 62.

RADIOLOGY

Post-graduate courses: 4, 8, 15, 16, 18, 19, 20, 25, 31, 39, 40, 42, 52, 59, 64, 75, 77.

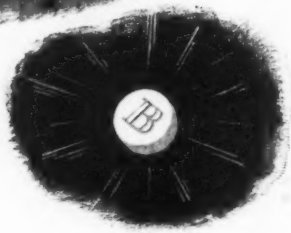
Residencies: 102, 104, 106, 114, 125, 128, 130, 131, 138, 142, 153, 162, 176, 178, 181, 183, 184, 187, 188, 190, 207, 215, 216, 219, 220, 221, 222, 225, 228, 229, 234, 237, 242, 249, 252, 253, 254, 262, 264, 273, 275, 276, 278, 289, 299, 306, 307, 313, 316, 317, 320, 321, 322, 324, 336, 355, 360, 362, 363, 364, 369, 374, 391, 398, 401, 415, 416, 423, 426, 433, 435, 443, 445, 447, 465, 481, 487, 489, 491, 492, 501, 511, 514, 522, 526, 527, 528, 529, 531, 534, 538, 541, 542, 547, 548, 549, 550, 552, 555, 558, 559, 561, 562, 563, 576, 581, 582, 585, 594, 600, 602, 603, 609, 613, 619, 623, 625, 626, 633, 634, 635, 657, 660, 661,

[Continued on page 138]

Cause

Effect

Relief



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SURGERY

Post-graduate courses: 8, 16, 17, 18, 19, 20, 21, 22, 39, 40, 42, 44, 46, 49, 57, 60, 63, 64, 67, 70, 71, 73.

Residencies: 81, 82, 85, 89, 93, 98, 99, 102, 105, 106, 111, 112, 117, 118, 119, 120, 124, 125, 126, 127, 128, 130, 131, 132, 135, 142, 147, 156, 160, 161, 162, 169, 170, 174, 175, 176, 178, 179, 181, 185, 187, 188, 191, 192, 194, 200, 207, 208, 211, 214, 215, 216, 218, 219, 220, 221, 222, 224, 225, 228, 229, 230, 234, 235, 236, 242, 252, 253, 254, 258, 262, 264, 266, 267, 271, 273, 276, 282, 284, 285, 286, 287, 289, 290, 291, 292, 293, 294, 295, 296, 298, 299, 300, 305, 306, 307, 313, 317, 320, 321, 324, 327, 329, 352, 353, 355, 357, 358, 360, 362, 363, 364, 366, 368, 369, 373, 374, 375, 376, 377, 391, 396, 398, 401, 402, 403, 409, 410, 413, 415, 417, 418, 423, 425, 426, 427, 428, 430, 431, 433, 435, 436, 442, 443, 445, 453, 454, 459, 462, 463, 471, 481, 483, 484, 485, 487, 489, 491, 493, 495, 496, 500, 501, 502, 505, 506, 511, 513, 514, 516, 522, 524, 525, 526, 527, 529, 531, 532, 535, 537, 539, 540, 541, 547, 548, 549, 550, 552, 555, 556, 558, 559, 561, 562, 563, 564, 576, 578, 580, 581, 587, 594, 600, 602, 603, 606, 608, 609, 611, 613, 614, 615, 616, 618, 619, 620, 622, 623, 625, 626, 627, 630, 631, 632, 633, 634, 635, 640, 641, 643, 644, 647, 648, 649, 653, 656, 657, 660, 663, 665, 666, 667, 668, 669, 671, 682, 683, 684, 685, 686, 687, 690, 691, 692, 693, 694, 696, 699, 703, 705, 706, 707, 710, 711, 712, 713, 716, 717, 720, 726, 728, 733, 739, 740, 742, 743, 744, 747, 748, 752, 754, 755, 757, 758, 760, 761, 762, 763, 764, 767, 769, 770, 775, 779, 781, 782, 783, 786, 787, 788, 793, 794, 795, 798, 799, 800, 801, 804, 805, 807.

THERAPY

Post-graduate courses: 39, 42, 64.

THORACIC SURGERY

Residencies: 113, 165, 206, 325, 355, 365, 408, 423, 457, 489, 501, 512, 515, 521, 524, 547, 571, 585, 609, 625, 663, 803.

TRAUMATIC SURGERY

Residencies: 549, 788.

TUBERCULOSIS

See "Chest Diseases."

TROPICAL MEDICINE

Post-graduate courses: 17, 34, 53.

UROLOGY

Post-graduate courses: 15, 17, 18, 19, 20, 30, 31, 40, 42, 73, 78.

Residencies: 81, 102, 106, 120, 128, 130, 131, 162, 175, 188, 207, 215, 220, 225, 228, 253, 262, 273, 276, 289, 306, 307, 317, 320, 321, 355, 360, 362, 363, 364, 373, 398, 401, 402, 403, 413, 426, 433, 436, 450, 451, 459, 466, 471, 489, 491, 496, 501, 514, 525, 547, 549, 552, 555, 558, 559, 561, 562, 563, 581, 585, 602, 603, 609, 625, 626, 635, 641, 649, 663, 671, 683, 686, 690, 694, 699, 710, 747, 763, 798, 801.

VENEREAL DISEASES

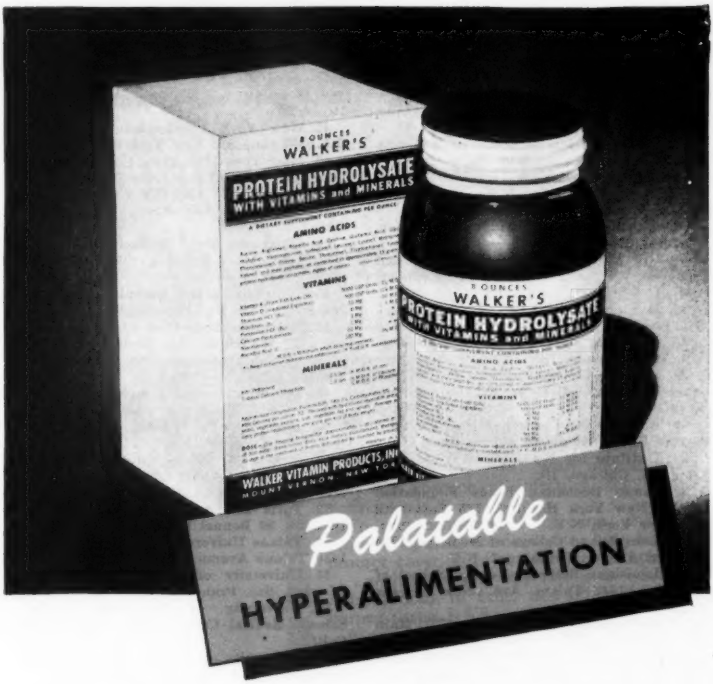
See also "Dermatology, Syphilology."

Post-graduate courses: 9, 28.

SCHOOLS AND AGENCIES OFFERING POST-GRADUATE INSTRUCTION

1. Alabama State Health Department; at Slossfield Health Center, Birmingham, Ala.
2. Albany Medical College, Albany, N.Y.
3. American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.
4. American College of Radiology, 20 N. Wacker Drive, Chicago, Ill.
5. American Institute for Psychoanalysis, 240 Central Park South, New York 21, N.Y.
6. American Orthopsychiatric Association, 149 East 73rd St., New York, N.Y.
7. Baylor University College of Medicine, 509 Lincoln Ave., Houston, Tex.
8. Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N.C.
9. Bureau of Social Hygiene, Department of Health, 125 Worth St., New York, N.Y.
10. California Medical Association, 450 Sutter St., San Francisco 8, Calif.
11. California Tuberculosis Association, 45 Second St., San Francisco, Calif.
12. Catholic University of America, Washington, D.C.
13. Chicago Maternity Center, 1336 South Newberry Ave., Chicago, Ill.
14. Children's Memorial Hospital, 707 Fullerton Avenue, Chicago, Ill.
15. College of Medical Evangelists, 312 Boyle Avenue, Los Angeles, Calif.
16. Columbia University Faculty of Medicine, 630 West 168th St., New York 32, N.Y.
17. Columbia University; at New York Post-Graduate Medical School, 303 East 20th St., New York 3, N.Y.; also at New York

[Continued on page 140]



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20. Duke University School of Medicine, Durham, N.C.

21. Emory University School of Medicine, 50 Armstrong St., Atlanta, Ga.

22. George Washington University School of Medicine, 1335 H St., N.W., Washington, 5, D.C.

23. Georgia Warm Springs Foundation, Warm Springs, Ga.

24. Gill Memorial Eye, Ear, and Throat Hospital, 711 South Jefferson St., Roanoke, Va.

25. Harvard Medical School, 25 Shattuck St., Boston 15, Mass.

26. Illinois Masonic Hospital, 834 Wellington Ave., Chicago, Ill.

27. Indiana University School of Medicine, 1040 West Michigan St., Indianapolis 7, Ind.

28. Institute for Control of Syphilis, 3400 Spruce St., Philadelphia, Pa.

29. Institute for Psychoanalysis, 43 East Ohio St., Chicago, Ill.

30. James Buchanan Brady Foundation of the New York Hospital, 525 East 68th St., New York, N.Y.

31. Long Island College of Medicine, 1313 Bedford Avenue, Brooklyn 2, N.Y.

32. Louisiana State University School of Medicine, 1542 Tulane Ave., New Orleans 13, La.

33. Maine Medical Association, 177C Main St., Waterville, Me.

34. Marquette University School of Medicine, 561 North 15th St., Milwaukee, Wis.

35. Medical College of Virginia, 12th and Marshall Sts., Richmond, Va.

36. Meharry Medical College, 1005-18th Ave. North, Nashville, Tenn.

37. Metropolitan State Hospital, Waltham, Mass.

38. Michael Reese Hospital, 29th St. and Ellis Ave., Chicago 16, Ill.

39. New York Medical College, 1 E. 105th St., New York, N.Y.

40. New York Polyclinic Medical School and Hospital, 345 W. 50th St., New York 19, N.Y.

41. New York Psychoanalytic Institute, 245 East 82nd St., New York 28, N.Y.

42. New York University College of Medicine, 477 First Avenue, New York 16, N.Y.

43. Ohio State University, College of Medicine, 11th and Neil Aves., Columbus 10, Ohio.

44. Oklahoma State Medical Association, 210 Plaza Court Building, Oklahoma City, Okla.

45. Philadelphia Psychoanalytic Institute, 206 South 13th St., Philadelphia 7, Pa.

46. Research Study Club of Los Angeles, Inc., 727 W. 7th St., Los Angeles, Cal.

47. St. Elizabeths Hospital, Washington, D.C.

48. Southern Pediatric Seminar, Saluda, N.C.

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50. State Sanatorium, Sanatorium, Miss.

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52. Tufts Medical School, Post-Graduate Division, 30 Bennet St., Boston 11, Mass.

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[Continued on page 143]

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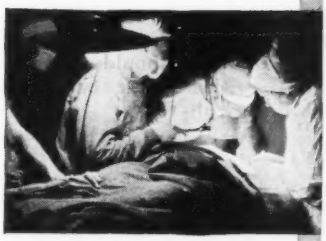

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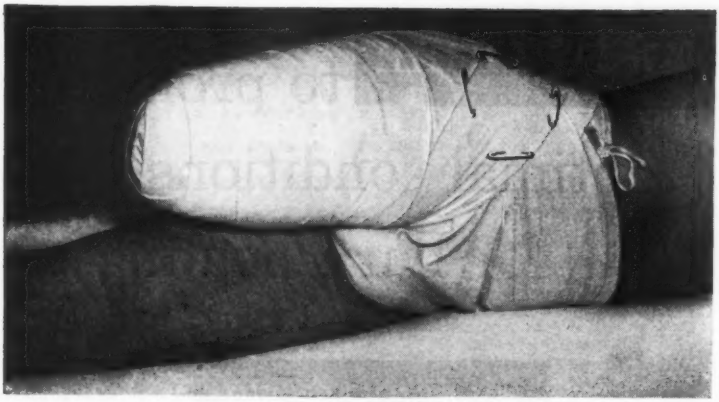

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63. University of Oklahoma School of Medicine, 801 N.E. 13th, Oklahoma City, Okla.

64. University of Oregon Medical School, Marquam Hill, Portland 1, Ore.

65. University of Pennsylvania, 237 Medical Laboratories, Philadelphia 4, Pa.

66. University of Pittsburgh School of Medicine, Bigelow Blvd., Pittsburgh, Pa.

67. University of Southern California School of Medicine, 3551 University Ave., Los Angeles, Calif.

68. University of Tennessee College of Medicine, 874 Union Ave., Memphis, Tenn.

69. University of Texas, 912 Avenue B, Galveston, Tex.

70. University of Texas School of Medicine, Galveston, Tex.

71. University of Vermont College of Medicine, Pearl St., College Park, Burlington, Vt.

72. University of Virginia Department of Medicine, University Station, Charlottesville, Va.

73. University of Wisconsin Medical School, 418 North Randall Ave., Madison 6, Wis.

74. Vaughan Memorial Clinic, 201 W. Franklin Street, Richmond, Va.

75. Wayne University College Medicine, 1516 St. Antoine St., Detroit, 1, Mich.; and also Wayne University School of Occupational Health, 4072 Penobscot Building, Detroit 26, Mich.

76. Western Reserve University School of Medicine, 2109 Adelbert Road, Cleveland 6, Ohio.

77. Wisconsin Anti-Tuberculosis Association, 324 East Wisconsin Ave., Milwaukee, Wis.

78. Woman's Medical College of Pennsylvania, Henry Avenue and Abbottsford Road, Philadelphia 29, Pa.

HOSPITALS OFFERING RESIDENCIES

ALABAMA; 79-87

79. Baptist Hospital, Birmingham, Ala.

80. Children's Hospital, Birmingham, Ala.

81. Jefferson and Hillman Hospitals, Birmingham, Ala.

82. Norwood Hospital, Birmingham, Ala.

83. St. Vincent's Hospital, Birmingham, Ala.

84. South Highlands Infirmary, Birmingham, Ala.

85. Employees' Hospital, Tennessee Coal, Iron and Railroad Company, Fairfield, Ala.

86. St. Margaret's Hospital, Montgomery, Ala.

ARIZONA; 87

87. St. Mary's Hospital and Sanatorium, Tucson, Ariz.

ARKANSAS; 88-89

88. Leo N. Levi Memorial Hospital, Hot Springs, Ark.

89. Baptist State Hospital, Little Rock, Ark.

[Continued on page 146]

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90. Kern General Hospital, Bakersfield, Calif.
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93. General Hospital of Fresno County, Fresno, Calif.
94. Arroyo del Valle Sanatorium, Livermore, Calif.
95. Livermore Sanitarium, Livermore, Calif.
96. Barlow Sanatorium, Los Angeles, Calif.
97. California Babies' and Children's Hospital, Los Angeles, Calif.
98. California Hospital, Los Angeles, Calif.
99. Cedars of Lebanon Hospital, Los Angeles, Calif.
100. Children's Hospital, Los Angeles, Calif.
101. Hospital of Good Samaritan, Los Angeles, Calif.
102. Los Angeles County Hospital, Los Angeles, Calif.
103. Orthopedic Hospital, Los Angeles, Calif.
104. St. Vincent's Hospital, Los Angeles, Calif.
105. Santa Fe Coast Lines Hospital, Los Angeles, Calif.
106. White Memorial Hospital, Los Angeles, Calif.
107. Pottenger Sanatorium and Clinic, Monrovia, Calif.
108. Bret Harte Sanatorium, Murphys, Calif.
109. Paradise Valley Sanitarium and Hospital, National City, Calif.
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111. Highland-Alameda County Hospital, Oakland, Calif.
112. Permanente Foundation Hospital, Oakland, Calif.
113. Olive View Sanatorium, Olive View, Calif.
114. Orange County General Hospital, Orange, Calif.
115. Huntington Memorial Hospital, Pasadena, Calif.
116. Monterey County Hospital, Salinas, Calif.
117. San Bernardino County Charity Hospital, San Bernardino, Calif.
118. San Diego County General Hospital, San Diego, Calif.
119. Children's Hospital, San Francisco, Calif.
120. Franklin Hospital, San Francisco, Calif.
121. French Hospital, San Francisco, Cal.
122. Green's Eye Hospital, San Francisco, Calif.
123. Langley-Porter Clinic, San Francisco, Calif.
124. Mary's Help Hospital, San Francisco, Calif.

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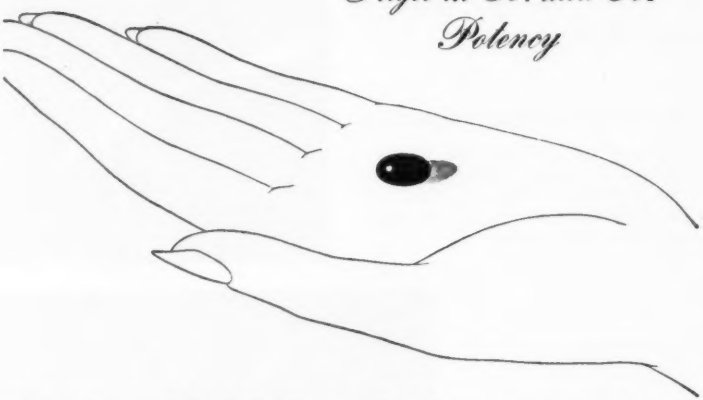

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E:	10 mg. Mixed Tocopherols

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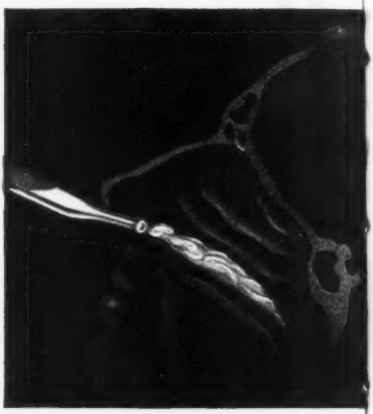

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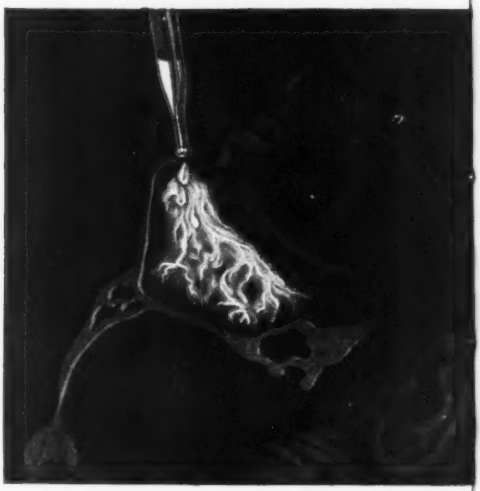

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127. St. Mary's Hospital, San Francisco, Calif.
128. San Francisco Hospital, San Francisco, Calif.
129. Shriners Hospital for Crippled Children, San Francisco, Calif.
130. Stanford University Hospitals, San Francisco, Calif.
131. University of California Hospital, San Francisco, Calif.
132. Santa Clara County Hospital, San Jose, Calif.
133. Fairmont Hospital, San Leandro, Calif.
134. St. Helena Sanitarium and Hospital, Sanitarium, Calif.
135. Santa Barbara Cottage Hospital, Santa Barbara, Calif.
136. Sonoma County Hospital, Santa Rosa, Calif.
137. Mendocino State Hospital, Talmadge, Calif.
138. Veterans Administration Hospital, West Los Angeles, Calif.

COLORADO; 139-150

139. Memorial Hospital, Colorado Springs, Col.
140. St. Francis Hospital and Sanatorium, Colorado Springs, Col.
141. Children's Hospital, Denver, Col.
142. Colorado General Hospital, Denver, Col.
143. Colorado Psychopathic Hospital, Denver, Col.
144. Denver General Hospital, Denver, Col.
145. Fitzsimons General Hospital, Denver, Col.
146. National Jewish Hospital, Denver, Col.
147. St. Luke's Hospital, Denver, Col.
148. Colorado State Hospital, Pueblo, Col.
149. St. Mary Hospital, Pueblo, Col.
150. Sanatorium of the Jewish Consumptives' Relief Society, Spivak, Col.

CONNECTICUIT; 151-166

151. Bristol Hospital, Bristol, Conn.
152. Greenwich Hospital, Greenwich, Conn.
153. Hartford Hospital, Hartford, Conn.
154. Institute of Living (Neuro-Psychiatric Institute of the Hartford Retreat), Hartford, Conn.
155. Municipal Hospitals, Hartford, Conn.
156. St. Francis Hospital, Hartford, Conn.
157. Undercliff, Meriden State Tuberculosis Sanatorium, Meriden, Conn.
158. Connecticut State Hospital, Middletown, Conn.
159. New Britain General Hospital, New Britain, Conn.
160. Grace Hospital, New Haven, Conn.
161. Hospital of St. Raphael, New Haven, Conn.
162. New Haven Hospital, New Haven, Conn.
163. Newington Home for Crippled Children, Newington, Conn.
164. Norwich State Hospital, Norwich, Conn.
165. Norwich State Tuberculosis Sanatorium, Norwich, Conn.
166. Laurel Heights State Tuberculosis Sanatorium, Shelton, Conn.

DELAWARE; 167-169

167. Delaware State Hospital, Farnhurst, Del.
168. Alfred I. du Pont Institute of the Nemours Foundation, Wilmington, Del.
169. Memorial Hospital, Wilmington, Del.

DISTRICT OF COLUMBIA; 170-184

170. Central Dispensary and Emergency Hospital, Washington, D.C.
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172. Columbia Hospital for Women and Lying-In Asylum, Washington, D.C.
173. Episcopal Eye, Ear, and Throat Hospital, Washington, D.C.
174. Freedmen's Hospital, Washington, D.C.
175. Gallinger Municipal Hospital, Washington, D.C.
176. Garfield Memorial Hospital, Washington, D.C.
177. George Washington University Hospital, Washington, D.C.
178. Georgetown University Hospital, Washington, D.C.
179. Providence Hospital, Washington, D.C.
180. St. Elizabeths Hospital, Washington, D.C.
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182. Tuberculosis Sanatorium (Glenn Dale, Md. P.O.) Washington, D.C.
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[Continued on page 152]

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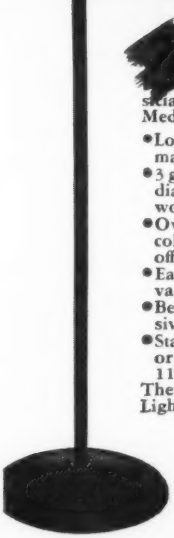

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187. James M. Jackson Memorial Hospital, Miami, Fla.

GEORGIA : 188-196

188. Grady Memorial Hospital, Atlanta, Ga.
189. Henrietta Egleston Hospital for Children, Atlanta, Ga.
190. Piedmont Hospital, Atlanta, Ga.
191. St. Joseph Infirmary, Atlanta, Ga.
192. University Hospital, Augusta, Ga.
193. Scottish Rite Hospital for Crippled Children, Decatur, Ga.
194. Emory University Hospital, Emory University, Ga.
195. Georgia Warm Springs Foundation, Warm Springs, Ga.

ILLINOIS : 197-245

196. Albert Steiner Clinic for Cancer and Allied Diseases, Atlanta, Ga.
197. St. Joseph's Hospital, Alton, Ill.
198. MacNeal Memorial Hospital, Berwyn, Ill.
199. St. Francis Hospital, Blue Island, Ill.
200. Augustana Hospital, Chicago, Ill.
201. Chicago Lying-In Hospital and Dispensary, Chicago, Ill.
202. Chicago Maternity Center, Chicago, Ill.
203. Chicago Memorial Hospital, Chicago, Ill.
204. Chicago State Hospital, Chicago, Ill.
205. Children's Memorial Hospital, Chicago, Ill.
206. City of Chicago Municipal Tuberculosis Hospital, Chicago, Ill.
207. Cook County Hospital, Chicago, Ill.
208. Grant Hospital, Chicago, Ill.
209. Henrotin Hospital, Chicago, Ill.
210. Illinois Eye and Ear Infirmary, Chicago, Ill.
211. Illinois Masonic Hospital, Chicago, Ill.
212. Illinois Neuropsychiatric Institute, Chicago, Ill.
213. Lewis Memorial Maternity Hospital, Chicago, Ill.
214. Mercy Hospital-Loyola University Clinics, Chicago, Ill.
215. Michael Reese Hospital, Chicago, Ill.
216. Mount Sinai Hospital, Chicago, Ill.
217. Municipal Contagious Disease Hospital, Chicago, Ill.
218. Norwegian-American Hospital, Chicago, Ill.
219. Passavant Memorial Hospital, Chicago, Ill.
220. Presbyterian Hospital, Chicago, Ill.
221. Provident Hospital, Chicago, Ill.
222. Research and Educational Hospitals, Chicago, Ill.
223. St. Anne's Hospital, Chicago, Ill.
224. St. Joseph's Hospital, Chicago, Ill.
225. St. Luke's Hospital, Chicago, Ill.
226. St. Vincent's Infant and Maternity Hospital, Chicago, Ill.
227. Shriners Hospital for Crippled Children, Chicago, Ill.
220. University of Chicago Clinics, Chicago, Ill.
229. Wesley Memorial Hospital, Chicago, Ill.
230. Women and Children's Hospital, Chicago, Ill.
231. Macon County Tuberculosis Sanatorium, Decatur, Ill.
232. Pleasant View Sanatorium, East St. Louis, Ill.
233. Elgin State Hospital, Elgin, Ill.
234. Evanston Hospital, Evanston, Ill.
235. St. Francis Hospital, Evanston, Ill.
236. Little Company of Mary Hospital, Evergreen Park, Ill.
237. Veterans Administration Hospital, Hines, Ill.
238. Manteno State Hospital, Manteno, Ill.
239. Methodist Hospital of Central Illinois, Peoria, Ill.
240. Peoria Municipal Tuberculosis Sanatorium, Peoria, Ill.
241. Peoria State Hospital, Peoria, Ill.
242. St. Francis Hospital, Peoria, Ill.
243. St. Anthony's Hospital, Rock Island, Ill.
244. Rockford Municipal Tuberculosis Sanatorium, Rockford, Ill.
245. Lake County Tuberculosis Sanatorium, Waukegan, Ill.

INDIANA : 246-259

246. Clinic Hospital, Bluffton, Ind.
247. Boehne Tuberculosis Hospital, Evansville, Ind.
248. St. Mary's Hospital, Evansville, Ind.
249. St. Margaret Hospital, Hammond, Ind.
250. Central State Hospital, Indianapolis, Ind.
252. Indiana University Medical Center, Indianapolis, Ind. [Continued on page 156]

TWO MEN IN A FIELD...

...and America's babies are better fed!

One of these men is a farmer, the other is a member of the Gerber Field Service working with him to produce better crops.

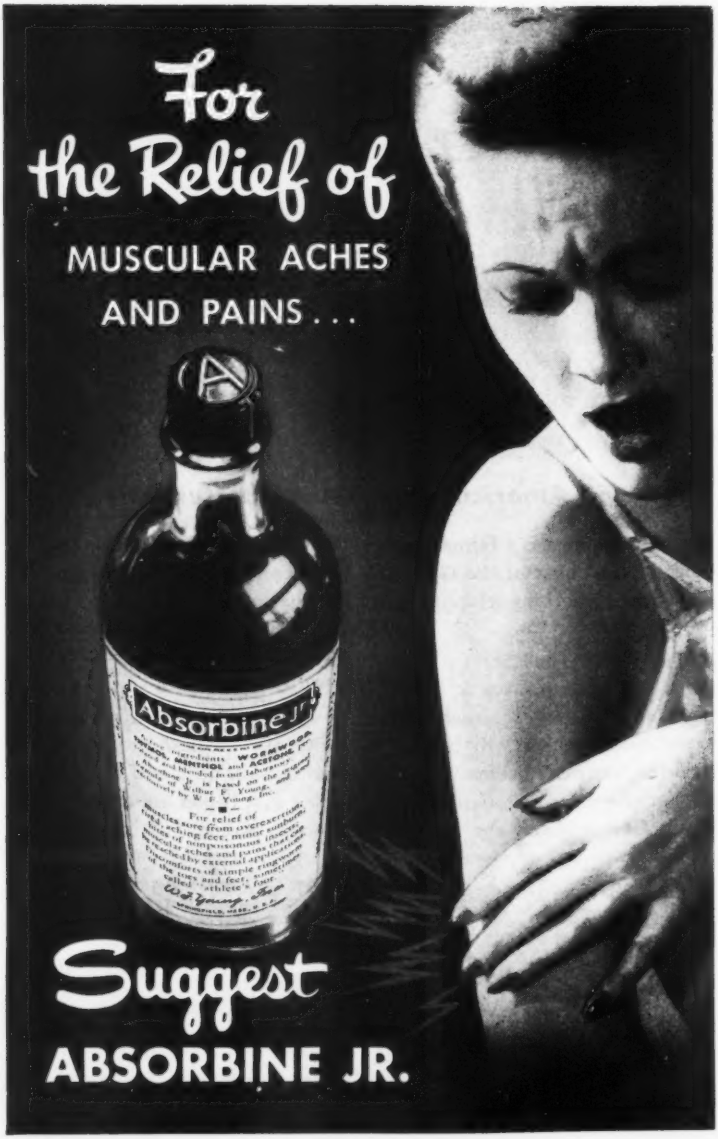
The Gerber Field Service is in touch with the growers of many crops such as peas, spinach and green beans, which will become food for America's babies. This is but one chapter in negotiations between Gerber — and the farmer.

Long before the crops are planted, Gerber field men are making assays of the soil to measure its specific qualities. Varieties of seeds are tested for suitability in making quality baby foods.

To us, our job is a partnership with the medical profession — a partnership dedicated to the principle that babies are the most important people!

Write for free samples of Gerber's Cereal Food and Gerber's Strained Oatmeal, address Gerber's, Dept. 223-6, Fremont, Mich.

CEREALS STRAINED FOODS CHOPPED FOODS


For
the Relief of
MUSCULAR ACHES
AND PAINS...
Absorbine Jr.
Suggest
ABSORBINE JR.

You Need These Features in an Ophthalmoscope...

Daylight lamp . . . gives fundus picture in its true colors.

Finger-touch change of lenses +20.00 to −25.00 D.

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Bausch & Lomb MAY Ophthalmoscope

Simplicity of design, precision and ruggedness of manufacture, and convenience of use, have made the Bausch & Lomb May Ophthalmoscope a physician's favorite for fast, accurate diagnosis. Now available for immediate delivery, your dealer can show the May Ophthalmoscope, the B&L Arc-Vue Otoscope, and attractively-cased diagnostic sets. Bausch & Lomb Optical Co., Rochester 2, N. Y.

BAUSCH & LOMB

ESTABLISHED 1853

INDIANA; 246-259 (Continued)

253. Indianapolis City Hospital, Indianapolis, Ind.
254. Methodist Hospital, Indianapolis, Ind.
255. Sunnyside Sanatorium, Indianapolis, Ind.
256. Lafayette Home Hospital, Lafayette, Ind.
257. Logansport State Hospital, Logansport, Ind.
258. Ball Memorial Hospital, Muncie, Ind.
259. Memorial Hospital, South Bend, Ind.

IOWA; 260-263

260. St. Luke's Methodist Hospital, Cedar Rapids, Iowa.
261. Iowa State Psychopathic Hospital, Iowa City, Iowa.
262. University Hospitals, Iowa City, Iowa.
263. State Sanatorium, Oakdale, Iowa.

KANSAS; 264-266

264. University of Kansas Hospitals, Kansas City, Kan.
265. Menninger Sanitarium, Topeka, Kan.
266. St. Francis Hospital, Wichita, Kan.

KENTUCKY; 267-271

267. St. Joseph's Hospital, Lexington, Ky.
268. U.S. Public Health Service Hospital, Lexington, Ky.
269. Jewish Hospital, Louisville, Ky.
270. Kosair Crippled Children's Hospital, Louisville, Ky.
271. Louisville General Hospital, Louisville, Ky.

LOUISIANA; 272-279

272. E. A. Conway Memorial Hospital, Monroe, La.
273. Charity Hospital, New Orleans, La.
274. Eye, Ear, Nose, and Throat Hospital, New Orleans, La.
275. Southern Baptist Hospital, New Orleans, La.
276. Touro Infirmary, New Orleans, La.
277. U.S. Marine Hospital, New Orleans, La.
278. Shreveport Charity Hospital, Shreveport, La.
279. Shriners Hospital for Crippled Children, Shrevesport, La.

MAINE; 280-281

280. Maine General Hospital, Portland, Me.
281. Western Maine Sanatorium, Greenwood Mt., Me.

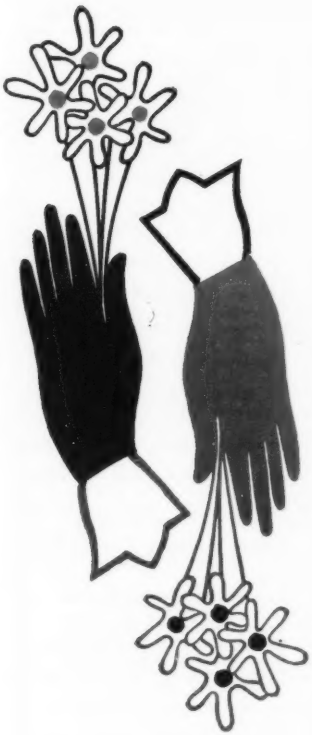
MARYLAND; 282-304

282. Baltimore City Hospitals, Baltimore, Md.
283. Baltimore Eye, Ear, and Throat Charity Hospital, Baltimore, Md.
284. Bon Secours Hospital, Baltimore, Md.
285. Church Home and Infirmary, Baltimore, Md.
286. Franklin Square Hospital, Baltimore, Md.
287. Hospital for Women, Baltimore, Md.
288. James Lawrence Kernan Hospital for Crippled Children, Baltimore, Md.
289. Johns Hopkins Hospital, Baltimore, Md.
290. Maryland General Hospital, Baltimore, Md.
291. Mercy Hospital, Baltimore, Md.
292. Provident Hospital and Free Dispensary, Baltimore, Md.
293. St. Agnes' Hospital, Baltimore, Md.
294. St. Joseph's Hospital, Baltimore, Md.
295. Sinai Hospital, Baltimore, Md.
296. South Baltimore General Hospital, Baltimore, Md.
297. Sydenham Hospital, Baltimore, Md.
298. Union Memorial Hospital, Baltimore, Md.
299. University Hospital, Baltimore, Md.
300. West Baltimore General Hospital, Baltimore, Md.
301. Suburban Hospital, Bethesda, Md.
302. Spring Grove State Hospital, Catonsville, Md.
303. Springfield State Hospital, Sykesville, Md.
304. Pratt Hospital, Towson, Md.

MASSACHUSETTS; 305-354

305. Beverly Hospital, Beverly, Mass.
306. Beth Israel Hospital, Boston, Mass.
307. Boston City Hospital, Boston, Mass.
308. Boston Floating Hospital, Boston, Mass.
309. Boston Lying-In Hospital, Boston, Mass.

[Continued on page 158]



gentle reminder

For the patient with functional constipation, 'AGAROL'* Emulsion serves as a gentle reminder rather than a violent summons. This emulsion of mineral oil with phenolphthalein and an agar-gel permits effective, yet gentle relief through:

1. Replacement of lubricating factors with highly emulsified mineral oil and a colloidal gel similar to mucin in its lubricating properties.
2. Replacement of moisture through its distinctive hydrophilic action.
3. Minimal threshold stimulation of peristaltic activity.

These actions are integrated to promote the formation of a consolidated, lubricated and easily passed fecal mass. Simultaneously, they encourage physiologic restoration of the patient's own evacuatory mechanisms.

William R. WARNER and Co. Inc. 113 WEST 18TH STREET, NEW YORK 11, N. Y.

Emulsion of mineral oil with phenolphthalein and an agar-gel. Dispensed in bottles of 6, 10 and 16 fluidounces.

'agarol'

*Trademark Reg. U. S. Pat. Off.

MASSACHUSETTS; 305-354 (Continued)

310. Boston Psychopathic Hospital, Boston, Mass.
311. Boston State Hospital, Boston, Mass.
312. Carney Hospital, Boston, Mass.
313. Children's Hospital, Boston, Mass.
314. Evangeline Booth Maternity Hospital and Home, Boston, Mass.
315. House of the Good Samaritan, Boston, Mass.
316. Joseph H. Pratt Diagnostic Hospital, Boston, Mass.
317. Lahey Clinic, Boston, Mass.
318. Long Island Hospital, Boston, Mass.
319. Massachusetts Eye and Ear Infirmary, Boston, Mass.
320. Massachusetts General Hospital, Boston, Mass.
321. Massachusetts Memorial Hospitals, Boston, Mass.
322. New England Deaconess Hospital, Boston, Mass.
323. New England Hospital for Women and Children, Boston, Mass.
324. Peter Bent Brigham Hospital, Boston, Mass.
325. Sanatorium Division, Boston City Hospital, Boston, Mass.
326. Free Hospital for Women, Brookline, Mass.
327. Cambridge Hospital, Cambridge, Mass.
328. St. Anne's Hospital, Fall River, Mass.
329. Truesdale Hospital, Fall River, Mass.
330. Foxboro State Hospital, Foxboro, Mass.
331. Framingham Union Hospital, Framingham, Mass.
332. Gardner State Hospital, Gardner, Mass.
333. Danvers State Hospital, Hathorne, Mass.
334. Malden Hospital, Malden, Mass.
335. Medfield State Hospital, Medfield, Mass.
336. Newton-Wellesley Hospital, Newton, Mass.
337. Northampton State Hospital, Northampton, Mass.
338. Grafton State Hospital, North Grafton, Mass.
339. Monson State Hospital, Palmer, Mass.
340. Rutland State Sanatorium, Rutland, Mass.
341. Salem Hospital, Salem, Mass.
342. Norfolk County Hospital, South Braintree, Mass.
343. Shriners Hospital for Crippled Children, Springfield, Mass.
344. Taunton State Hospital, Taunton, Mass.
345. Tewksbury State Hospital and Infirmary, Tewkbury, Mass.
346. Pondville Hospital, Walpole, Mass.
347. Middlesex County Sanatorium, Waltham, Mass.
348. McLean Hospital, Waverley, Mass.
349. Westboro State Hospital, Westboro, Mass.
350. Westfield State Sanatorium, Westfield, Mass.
351. Belmont Hospital, Worcester, Mass.
352. Memorial Hospital, Worcester, Mass.
353. Worcester City Hospital, Worcester, Mass.
354. Worcester State Hospital, Worcester, Mass.

MICHIGAN; 355-389

355. University Hospital, Ann Arbor, Mich.
356. American Legion Hospital, Battle Creek, Mich.
357. Alexander Blain Hospital, Detroit, Mich.
358. Charles Godwin Jennings Hospital, Detroit, Mich.
359. Children's Hospital, Detroit, Mich.
360. City of Detroit Receiving Hospital, Detroit, Mich.
361. Florence Crittenton Hospital, Detroit, Mich.
362. Grace Hospital, Detroit, Mich.
363. Harper Hospital, Detroit, Mich.
364. Henry Ford Hospital, Detroit, Mich.
365. Herman Kiefer Hospital, Detroit, Mich.
366. Mount Carmel Mercy Hospital, Detroit, Mich.
367. Parkside Hospital, Detroit, Mich.
368. Providence Hospital, Detroit, Mich.
369. St. Mary's Hospital, Detroit, Mich.
370. Saratoga General Hospital, Detroit, Mich.
371. Shurly Hospital, Detroit, Mich.
372. Woman's Hospital, Detroit, Mich.
373. Eloise Hospital and Infirmary, Eloise, Mich.
374. Hurley Hospital, Flint, Mich.
375. Blodgett Memorial Hospital, Grand Rapids, Mich.
376. Butterworth Hospital, Grand Rapids, Mich.

[Continued on page 163

"Your cardiograph is normal. Nothing abnormal showed up in the fluoroscope. But you do have a tendency to O.O.* which we can easily clean up..."

● MORE AND MORE physicians are prescribing Astring-O-Sol. *And why?*

Because it is effective for cleansing and stimulating oral tissues. Germicidal at full strength ... Astring-O-Sol is useful for minor surface cuts.

It's concentrated to last longer ... just a dash in a glass of water makes an effective mouth wash with a refreshing, pleasant flavor.

Samples are available to the profession, upon request.

* Oral Offense

ASTRING-O-SOL

EFFECTIVE MOUTH WASH

Frederick Stearns & Company *Division,* Detroit, Michigan

RELIEF IN NEURALGIA

Recent pharmacologic studies show that counter-irritants not only increase the local blood supply through reflex action, but tend to modify internal pathology by affecting trophic or vasomotor nerves supplying these remote tissues. Thus, again is the value of an effective counter-irritant such as MINIT-RUB affirmed in relief of uncomplicated neuralgias.

MINIT-RUB acts speedily to give rapid relief from the wearing pain of neuralgia—pain which impedes success in the treatment of the condition itself. As an adjuvant to treatment, home massage with MINIT-RUB between office visits is suggested to make the patient easier—more responsive.

RECOMMEND SUPPLEMENTARY HOME MASSAGE

WITH MINIT-RUB

TO YOUR NEURALGIC PATIENTS

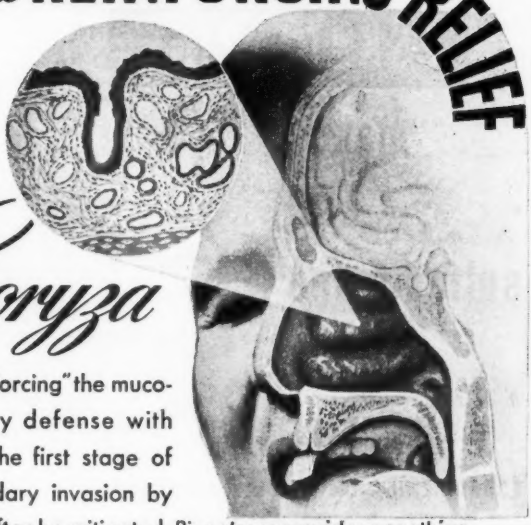
THE MODERN RUB-IN

STAINLESS • GREASELESS • VANISHING

A Product of BRISTOL-MYERS COMPANY
19ME West 50th Street, New York 20, N. Y.

to provide **REINFORCING RELIEF**

IN *Coryza*



BY "reinforcing" the muco-ciliary defense with *Pineoleum* in the first stage of coryza, secondary invasion by bacteria may often be mitigated. *Pineoleum* provides a soothing film of liquid petrolatum which aids in correcting dryness, removing incrustations and thus promoting ciliary activity. At the same time, it reduces congestion by gently shrinking the swollen turbinates—and its action outlasts that of aqueous sprays.

■ The efficiency of *Pineoleum* in providing symptomatic relief in nasal manifestations of the common cold and other forms of rhinitis, is attested by the fact that, for over 40 years, it has been a favorite of many physicians everywhere.

THE PINEOLEUM COMPANY, NEW YORK 4, N. Y.

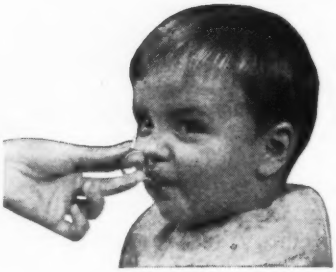
FORMULA: 'Pineoleum' contains camphor (.50%), menthol (.50%), eucalyptus oil (.56%), pine needle oil (1.00%), and cassia oil (.07%) in a base of doubly-refined liquid petrolatum—plain or with ephedrine (.50%).

PINEOLEUM
(Reg. U. S. Pat. Off.)
PLAIN OR WITH EPHEDRINE

PROTECTS *WHILE IT RELIEVES*

ESKADIAZINE

makes oral sulfadiazine therapy easier



ESKADIAZINE—the ideal oral sulfadiazine—has these three advantages:—

1 **Fluid Form.** This new fluid sulfadiazine is the ideal oral dosage form, especially for infants and children, and also for the many adults who object to tablet medication.

2 **Exceptional Palatability.** Eskadiazine is so surprisingly palatable and pleasant in consistency that it is accepted willingly by all types of patients. Children actually like to take it.

3 **More Rapid Absorption.** The findings of a recent clinical study by Flippin and associates (Am. J. M. Sc., Aug. 1945) indicate that with Eskadiazine desired serum levels may be far more rapidly attained than with sulfadiazine administered in tablet form.

Smith, Kline & French Laboratories, Phila., Pa.

S.K.F.'s new, outstandingly palatable fluid sulfadiazine for oral use

MICHIGAN; 355-389 (Continued)

377. St. Mary's Hospital, Grand Rapids, Mich.
378. Michigan State Sanatorium, Howell, Mich.
379. Kalamazoo State Hospital, Kalamazoo, Mich.
380. Ingham Sanatorium, Lansing Mich.
381. Morgan Heights Sanatorium, Marquette, Mich.
382. Mercy Hospital, Muskegon, Mich.
383. William H. Maybury Sanatorium, Northville, Mich.
384. Oakland County Tuberculosis Hospital, Pontiac, Mich.
385. Pontiac State Hospital, Pontiac, Mich.
386. St. Joseph Mercy Hospital, Pontiac, Mich.
387. Traverse City State Hospital, Traverse City, Mich.
388. Wyandotte General Hospital, Wyandotte, Mich.
389. Ypsilanti State Hospital, Ypsilanti, Mich.

MINNESOTA; 390-407

390. St. Luke's Hospital, Duluth, Minn.
391. St. Mary's Hospital, Duluth, Minn.
392. Hibbing General Hospital, Hibbing, Minn.
393. Eitel Hospital, Minneapolis, Minn.
394. Fairview Hospital, Minneapolis, Minn.
395. Lutheran Deaconess Home and Hospital, Minneapolis, Minn.
396. Minneapolis General Hospital, Minneapolis, Minn.
397. St. Mary's Hospital, Minneapolis, Minn.
398. University Hospitals, Minneapolis, Minn.
399. Nopeming Sanatorium, Nopeming, Minn.
400. Glen Lake Sanatorium, Oak Terrace, Minn.
401. Mayo Foundation, Rochester, Minn.
402. Ancker Hospital, St. Paul, Minn.
403. Charles T. Miller Hospital, St. Paul, Minn.
404. Gillette State Hospital for Crippled Children, St. Paul, Minn.
405. Midway Hospital, St. Paul, Minn.
406. Northern Pacific Beneficial Association Hospital, St. Paul, Minn.
407. St. Peter State Hospital, St. Peter, Minn.

MISSISSIPPI; 408

408. Mississippi State Sanatorium, Sanatorium, Miss.

MISSOURI; 409-438

409. St. Louis County Hospital, Clayton, Mo.
410. Ellis Fischel State Cancer Hospital, Columbia, Mo.
411. State Hospital No. I, Fulton, Mo.
412. Children's Mercy Hospital, Kansas City, Mo.
413. Kansas City General Hospital, Kansas City, Mo.
414. Kansas City Municipal Tuberculosis Hospital, Kansas City, Mo.
415. Research Hospital, Kansas City, Mo.
416. St. Joseph Hospital, Kansas City, Mo.
417. St. Luke's Hospital, Kansas City, Mo.
418. St. Mary's Hospital, Kansas City, Mo.
419. Robert Koch Hospital, Koch, Mo.
420. State Hospital No. 2, St. Joseph, Mo.
421. Alexian Brothers Hospital, St. Louis, Mo.
422. Barnard Free Skin and Cancer Hospital, St. Louis, Mo.
423. Barnes Hospital, St. Louis, Mo.
424. City Sanitarium, St. Louis, Mo.
425. De Paul Hospital, St. Louis, Mo.
426. Homer G. Phillips Hospital, St. Louis, Mo.
427. Jewish Hospital, St. Louis, Mo.
428. Missouri Baptist Hospital, St. Louis, Mo.
429. Mt. St. Rose Sanatorium, St. Louis, Mo.
430. St. Anthony's Hospital, St. Louis, Mo.
431. St. John's Hospital, St. Louis, Mo.
432. St. Louis Children's Hospital, St. Louis, Mo.
433. St. Louis City Hospital, St. Louis, Mo.
434. St. Louis Maternity Hospital, St. Louis, Mo.
435. St. Luke's Hospital, St. Louis, Mo.
436. St. Mary's Group of Hospitals, St. Louis, Mo.

[Continued on page 164]

Spendthrift

I wrote a prescription for the lad and told his mother it would be rather expensive, since it contained a costly drug. Later on that day she phoned. "Johnny just can't keep that medicine down," she announced in a troubled voice. "He's lost a dollar's worth already."

—C. B. SUMMERS, M.D.

MISSOURI: 409-438 (Continued)

437. St. Vincent's Sanitarium, St. Louis, Mo.

438. Shriners Hospital for Crippled Children, St. Louis, Mo.

NEBRASKA: 439-445

439. Hastings State Hospital, Ingleside, Neb.

440. Nebraska Orthopedic Hospital, Lincoln, Neb.

441. Norfolk State Hospital, Norfolk, Neb.

442. Bishop Clarkson Memorial Hospital, Omaha, Neb.

443. Creighton Memorial St. Joseph's Hospital, Omaha, Neb.

444. Douglas County Hospital, Omaha, Neb.

445. University of Nebraska Hospital, Omaha, Neb.

NEW HAMPSHIRE; 446-449

446. New Hampshire State Hospital, Concord, N.H.

447. Mary Hitchcock Memorial Hospital, Hanover, N.H.

448. Elliot Hospital, Manchester, N.H.

449. Sacred Heart Hospital, Manchester, N.H.

NEW JERSEY; 450-470

450. Atlantic City Hospital, Atlantic City, N.J.

451. Bayonne Hospital and Dispensary, Bayonne, N.J.

452. Essex County Hospital for Contagious Disease, Belleville, N.J.

453. Cooper Hospital, Camden, N.J.

454. West Jersey Homeopathic Hospital, Camden, N.J.

455. New Jersey Sanatorium for Tuberculous Diseases, Glen Gardner, N.J.

456. New Jersey State Hospital, Greystone Park, N.J.

457. Hudson County Tuberculosis Hospital, Jersey City, N.J.

458. Hudson County Tuberculosis Hospital and Sanatorium, Jersey City, N.J.

459. Jersey City Hospital, Jersey City, N.J.

460. Margaret Hague Maternity Hospital, Jersey City, N.J.

461. New Jersey State Hospital, Marlboro, N.J.

462. Mountainside Hospital, Montclair, N.J.

463. Burlington County Hospital, Mount Holly, N.J.

464. Hospital and Home for Crippled Children, Newark, N.J.

465. Newark Beth Israel Hospital, Newark, N.J.

466. Newark City Hospital, Newark, N.J.

467. Newark Eye and Ear Infirmary, Newark, N.J.

468. New Jersey Orthopedic Hospital and Dispensary, Orange, N.J.

469. New Jersey State Hospital, Trenton, N.J.

470. Essex Mountain Sanatorium, Verona, N.J.

NEW YORK; 471-599

471. Albany Hospital, Albany, N.Y.

472. Anthony N. Brady Maternity Home, Albany, N.Y.

473. Bender Hygienic Laboratory, Albany, N.Y.

474. Auburn City Hospital, Auburn, N.Y.

475. Montefiore Hospital Country Sanatorium, Bedford Hills, N.Y.

476. Binghamton State Hospital, Binghamton, N.Y.

477. Pilgrim State Hospital, Brentwood, N.Y.

478. Beth-El Hospital, Brooklyn, N.Y.

479. Brooklyn Cancer Institute, Brooklyn, N.Y.

480. Brooklyn Eye and Ear Hospital, Brooklyn, N.Y.

481. Brooklyn Hospital, Brooklyn, N.Y.

482. Brooklyn State Hospital, Brooklyn, N.Y.

483. Coney Island Hospital, Brooklyn, N.Y.

484. Cumberland Hospital, Brooklyn, N.Y.

485. Greenpoint Hospital, Brooklyn, N.Y.

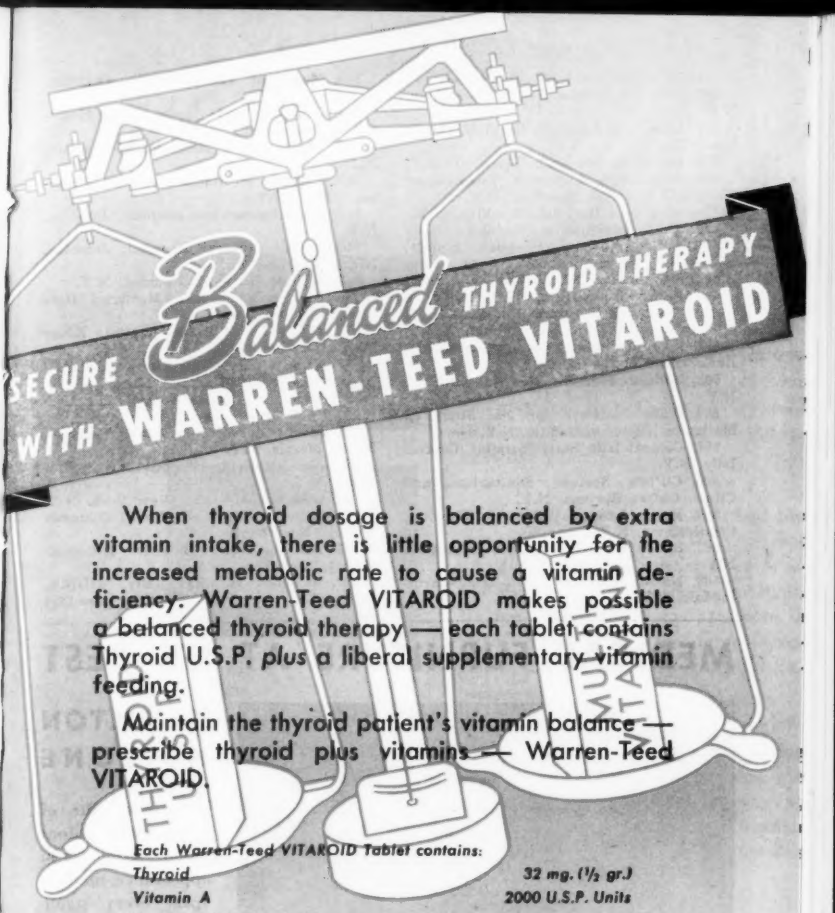
486. Israel-Zion Hospital, Brooklyn, N.Y.

487. Jewish Hospital, Brooklyn, N.Y.

488. Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N.Y.

489. Kings County Hospital, Brooklyn, N.Y.

[Continued on page 166]



When thyroid dosage is balanced by extra vitamin intake, there is little opportunity for the increased metabolic rate to cause a vitamin deficiency. Warren-Teed VITAROID makes possible a balanced thyroid therapy — each tablet contains Thyroid U.S.P. *plus* a liberal supplementary vitamin feeding.

Maintain the thyroid patient's vitamin balance — prescribe thyroid plus vitamins — Warren-Teed VITAROID.

Each Warren-Teed VITAROID Tablet contains:	
Thyroid	*32 mg. (½ gr.)*
Vitamin A	*2000 U.S.P. Units*
Synthetic Oleovitamin D (Activated Ergosterol)	*200 U.S.P. Units.*
Ascorbic Acid	*15.0 mg.*
Riboflavin	*1.0 mg.*
Thiamine Hydrochloride	*0.5 mg.*
Nicotinamide	*5.0 mg.*

WARREN-TEED

Medicaments of Exacting Quality Since 1920

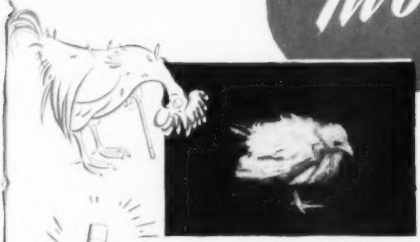
THE WARREN-TEED PRODUCTS COMPANY, COLUMBUS 8, OHIO

Warren-Teed Ethical Pharmaceuticals: capsules, elixirs, ointments, sterilized solutions, syrups, tablets. Write for literature.

NEW YORK; 471-599 (Continued)

490. Kingston Avenue Hospital, Brooklyn, N.Y.
491. Long Island College Hospital, Brooklyn, N.Y.
492. Methodist Hospital, Brooklyn, N.Y.
493. Norwegian Lutheran Deaconesses' Home and Hospital, Brooklyn, N.Y.
494. St. John's Hospital, Brooklyn, N.Y.
495. St. Mary's Hospital, Brooklyn, N.Y.
496. Buffalo General Hospital, Buffalo, N.Y.
497. Buffalo Hospital, Buffalo, N.Y.
498. Buffalo State Hospital, Buffalo, N.Y.
499. Children's Hospital, Buffalo, N.Y.
500. Deaconess Hospital, Buffalo, N.Y.
501. Edward J. Meyer Memorial Hospital, Buffalo, N.Y.
502. Millard Fillmore Hospital, Buffalo, N.Y.
503. State Institute for the Study of Malignant Diseases, Buffalo, N.Y.
504. Central Islip State Hospital, Central Islip, N.Y.
505. Clifton Springs Sanitarium and Clinic, Clifton Springs, N.Y.
506. Mary Imogene Bassett Hospital, Cooperstown, N.Y.
507. St. Joseph Hospital, Far Rockaway, N.Y.
508. Nassau County Sanatorium, Farmingdale, N.Y.
509. Municipal Sanatorium, Otisville, N.Y.
510. Gowanda State Homeopathic Hospital, Helmuth, N.Y.
511. Meadowbrook Hospital, Hempstead, N.Y.
512. Herman M. Biggs Memorial Hospital, Ithaca, N.Y.
513. Mary Immaculate Hospital, Jamaica, N.Y.
514. Queens General Hospital, Jamaica, N.Y.
515. Triboro Hospital, Jamaica, N.Y.
516. Charles S. Wilson Memorial Hospital, Johnson City, N.Y.
517. Kings Park State Hospital, Kings Park, N.Y.
518. Kingston Hospital, Kingston, N.Y.
519. Marcy State Hospital, Marcy, N.Y.
520. Middletown State Homeopathic Hospital, Middletown, N.Y.
521. Mount Morris Tuberculosis Hospital, Mount Morris, N.Y.
522. New Rochelle Hospital, New Rochelle, N.Y.
523. Beekman Hospital, New York, N.Y.
524. Bellevue Hospital (Div. I-Columbia Univ.), New York, N.Y.
525. Bellevue Hospital (Div. II-Cornell Univ.), New York, N.Y.
526. Bellevue Hospital (Div. III-N.Y. Univ.), New York, N.Y. [Cont. on page 168]

A TALE OF Two Chickens



Chick No. 531

Chick No. 633

● Here is a chicken—one of the scrawniest, most miserable-looking chickens you ever saw. He got what was *supposed* to be a good diet, including *all* the established vitamins.

● Now, *this* barnyard bonanza had the same start in life, and got the same diet . . . *plus* 1% of the Special Liver Fraction used as the base of Beta-Concemin. He has better and longer feathers, a terrific weight advantage, more hemoglobin, and an infinitely better life expectancy.

● **FOR YOUR PATIENTS,** extra-good-tasting Elixir Beta-Concemin provides the established B vitamins in high potency, fortified with this Special Liver Fraction rich in the *whole* B complex from this complete, natural source.

BETA-CONCEMIN
BRAND
VITAMIN B COMPLEX

ELIXIR (2 or 3 teaspoonfuls daily)—in 4-oz., 12-oz., gallons.

TABLETS (2 or 3 daily)—in 100's and 1000's.

CAPSULES (4 to 6 daily)—in 100's and 1000's.
With Ferrous Sulfate

Trademark "Beta-Concemin" Reg. U. S. Pat. Off.

MERRELL
110th Year

THE WM. S. MERRELL COMPANY CINCINNATI, U. S. A.

NEW YORK: 471-599 (Continued)

527. Bellevue Hospital (Div. IV-Open Div.), New York, N.Y.
528. Beth Israel Hospital, New York, N.Y.
529. Bronx Hospital, New York, N.Y.
530. Columbia-Presbyterian Medical Center, New York, N.Y.
531. Flower and Fifth Avenue Hospitals, New York, N.Y.
532. Fordham Hospital, New York, N.Y.
533. French Hospital, New York, N.Y.
534. Goldwater Memorial Hospital, New York, N.Y.
535. Gouveneur Hospital, New York, N.Y.
536. Harlem Eye and Ear Hospital, New York, N.Y.
537. Harlem Hospital, New York, N.Y.
538. Hospital for Joint Diseases, New York, N.Y.
539. Hospital for Special Surgery, New York, N.Y.
540. Knickerbocker Hospital, New York, N.Y.
541. Lenox Hill Hospital, New York, N.Y.
542. Lincoln Hospital, New York, N.Y.
543. Lying-In Hospital, New York, N.Y.
544. Manhattan Eye, Ear and Throat Hospital, New York, N.Y.
545. Manhattan State Hospital, New York, N.Y.
546. Memorial Hospital, New York, N.Y.
547. Metropolitan Hospital, New York, N.Y.
548. Montefiore Hospital for Chronic Diseases, New York, N.Y.
549. Morrisania City Hospital, New York, N.Y.
550. Mount Sinai Hospital, New York, N.Y.
551. New York City Cancer Institute Hospital, New York, N.Y.
552. New York City Hospital, New York, N.Y.
553. New York Eye and Ear Infirmary, New York, N.Y.
554. New York Foundling Hospital, New York, N.Y.
555. New York Hospital, New York, N.Y.
556. New York Infirmary for Women and Children, New York, N.Y.
557. New York Orthopaedic Disp. and Hospital, New York, N.Y.
558. New York Polyclinic Medical School and Hospital, New York, N.Y.
559. New York Post-Graduate Medical School and Hospital, New York, N.Y.
560. New York State Psychiatric Institute and Hospital, New York, N.Y.
561. Presbyterian Hospital, New York, N.Y.
562. Roosevelt Hospital, New York, N.Y.
563. St. Luke's Hospital, New York, N.Y.
564. St. Vincent's Hospital, New York, N.Y.
565. Sloane Hospital for Women, New York, N.Y.

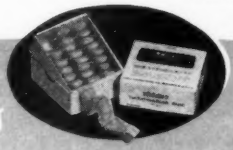
[Continued on page 171]

"topical

in a strict sense of the term..."

"...sulfathiazole gum provides a method of chemotherapy for oropharyngeal use and is topical in a strict sense of the term, as shown by the extremely low blood levels of sulfathiazole resulting from intensive dosage with the preparation."

—FOX, NOAH, ET. AL.: EFFECT OF SULFATHIAZOLE IN CHEWING GUM IN CERTAIN OROPHARYNGEAL INFECTIONS, ARCH. OF OTOLARYNGOLOGY, *41*:278-283 (APRIL) 1945.



White's

SULFATHIAZOLE GUM

When a single tablet of pleasantly flavored Sulfathiazole Gum is chewed for one-half to one hour it provides a high salivary concentration of locally active sulfathiazole, averaging 70 mg. per cent. Moreover, resultant blood levels of the drug, even with maximal dosage, are so low (rarely reaching 0.5 to 1 mg. per cent) that systemic toxic reactions are virtually obviated.

INDICATIONS: *Local treatment of sulfonamide-susceptible infections of oropharyngeal areas; acute tonsillitis and pharyngitis—septic sore throat—infectious gingivitis and stomatitis—Vincent's infection. Also indicated in the prevention of local infection secondary to oral and pharyngeal surgery.*

DOSAGE: *One tablet chewed for one-half to one hour at intervals of one to four hours, depending upon the severity of the condition. If preferred, several tablets—rather than a single tablet—may be chewed successively during each dosage period without significantly increasing the amount of sulfathiazole systemically absorbed.*

IMPORTANT: *Please note that your patient requires your prescription to obtain this product from the pharmacist.*

Available in packages of 24 tablets, sanitaped, in slip-sleeve prescription boxes

A PRODUCT OF White LABORATORIES, INC.
Pharmaceutical Manufacturers, Newark 7, N. J.

PROMPT RELIEF IN

ASTHMA

15 minutes following the ingestion of a Tedral tablet, the average asthmatic obtains relief. 2 gr. theophylline relax the smooth muscles of the bronchi and promote diuresis . . . 3/8 gr. ephedrine dilates the lumen of the bronchi and reduces edematous swelling . . . 1/8 gr. phenobarbital contributes a moderate sedative action. *Dosage:* 1 or 2 tablets three times daily. Also, in Enteric Coated tablets for delayed action during the night.

TEDRAL . . . QUICK . . . CONVENIENT

The Maltine Company NEW YORK 22

NEW YORK: 471-599 (Continued)

566. Sydenham Hospital, New York, N.Y.
567. U.S. Marine Hospital, New York, N.Y.
568. Willard Parker Hospital, New York, N.Y.
569. Woman's Hospital, New York, N.Y.
570. St. Lawrence State Hospital, Ogdensburg, N.Y.
571. Homer Folks Tuberculosis Hospital, Oneonta, N.Y.
572. Rockland State Hospital, Orangeburg, N.Y.
573. Hudson River State Hospital, Poughkeepsie, N.Y.
574. Creedmoor State Hospital, Queens Village, N.Y.
575. New York State Hospital, Ray Brook, N.Y.
576. Genesee Hospital, Rochester, N.Y.
577. Iola-Monroe County Tuberculosis Sanatorium, Rochester, N.Y.
578. Rochester General Hospital, Rochester, N.Y.
579. Rochester State Hospital, Rochester, N.Y.
580. St. Mary's Hospital, Rochester, N.Y.
581. Strong Memorial and Rochester Municipal Hospitals, Rochester, N.Y.
582. Ellis Hospital, Schenectady, N.Y.
583. Schenectady County Tuberculosis Hospital, Schenectady, N.Y.
584. Richmond Memorial Hospital, Staten Island, N.Y.
585. Sea View Hospital, Staten Island, N.Y.
586. General Hospital, Syracuse, N.Y.
587. Hospital of the Good Shepherd, Syracuse, N.Y.
588. Syracuse Psychopathic Hospital, Syracuse, N.Y.
589. Syracuse Memorial Hospital, Syracuse, N.Y.
590. Syracuse University Medical Center, Syracuse, N.Y.
591. Samaritan Hospital, Troy, N.Y.
592. Trudeau Sanatorium, Trudeau, N.Y.
593. Utica State Hospital, Utica, N.Y.
594. Grasslands Hospital, Valhalla, New York.
595. Wyoming County Community Hospital, Warsaw, N.Y.
596. Jefferson County Sanatorium, Watertown, N.Y.
597. New York State Reconstruction Home, West Haverstraw, N.Y.
598. New York Hospital-Westchester Division, White Plains, N.Y.
599. Harlem Valley State Hospital, Wingdale, N.Y.

[Continued on page 175]

no bribe, no wheedle, no threat

The many youngsters who require the appetite-stimulating impetus of vitamin B complex will take 'Ryzamin-B' No. 2 without bribe, threat, or coaxing. They love—and actually ask for—this flavorsome, honey-like preparation—as a spread with jam or peanut butter, dissolved in milk, fruit juice or other beverage, or directly from its special measuring spoon. 'Ryzamin-B' No. 2 caters to the finicky palate of young and old.

'Ryzamin-B' No. 2 is a concentrate of oryza sativa (American rice) polishings, its rich natural vitamin B enhanced with pure crystalline B factors.

Only three grams daily provide: Vitamin B_1 (Thiamine Hydrochloride) 3 mgm. (1,000 U.S.P. Units); Vitamin B_2 (Riboflavin) 2 mgm.; Nicotinamide 20 mgm. and other factors of the B complex. Gram measuring spoon with each packing... Tubes of 2 oz. and bottles of 8 oz.

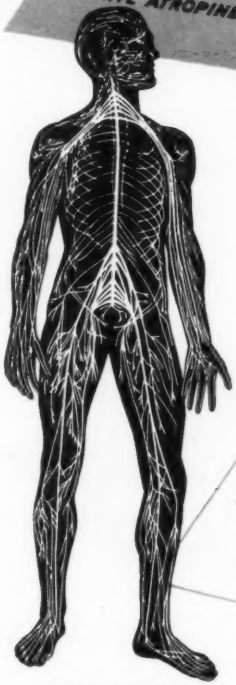
'Ryzamin-B' BRAND
RICE POLISHINGS CONCENTRATE
No. 2
WITH ADDED THIAMINE HYDROCHLORIDE, RIBOFLAVIN AND NICOTINAMIDE
'Ryzamin-B' registered trademark.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
9 & 11 EAST 41ST ST.
NEW YORK 17

METROPINE

REG. U.S. PAT. OFF.

METHYL ATROPINE NITRATE (STRASENBURGH)



NERVE SYSTEM

* the SAFE, RELIABLE SPASMOLYTIC.....

METROPINE provides *maximum* spasmolytic action with *minimum* toxicity. Large and effective doses may be given without danger of reaching the toxic level. Metropine is indicated wherever routine antispasmodic treatment is required.

Available in 1/60 grain tablets, in 1/120 grain soluble tablets and also combined with Phenobarbital. Write for complete information to Dept. ME-C.

R. J. STRASENBURGH Co.

PHARMACEUTICAL CHEMISTS SINCE 1886

ROCHESTER 4, NEW YORK

The KELEKET "W" Table, Railmounted Tube Stand and 200 MA Multicron Control

THE PHYSICIAN who wants in his office the very finest X-ray equipment available will find what he desires in this KELEKET diagnostic combination which embodies many advanced features developed in X-ray.

This is the same efficient KELEKET combination that is now being used in many of the best equipped X-ray laboratories and hospitals. It is fully adequate for all radiographic and fluoroscopic technics in the vertical, horizontal or Trendelenburg positions.

Many exclusive advancements, perfected by KELEKET, insure long-time service and simple, trouble-free operation. The control unit is the famous KELEKET 200 MA. Multicron which performs many operations automatically, thus eliminating manual adjustments.

Your patients will appreciate your ability to confirm quickly *right in your own office* the clinical diagnoses with the best available radiographic evidence. Learn now about the many features which make this KELEKET combination group so outstanding! Ask the KELEKET representative in your city or write us.

THE **Kelley-Koett** Manufacturing Co.

KELEKET-THE FINEST TRADITION IN X-RAY

2003 WEST FOURTH ST., COVINGTON, KY.

NORTH CAROLINA: 600-609

600. Charlotte Memorial Hospital, Charlotte, N.C.
601. Mercy Hospital, Charlotte, N.C.
602. Duke Hospital, Durham, N.C.
603. Watts Hospital, Durham, N.C.
604. Highsmith Hospital, Fayetteville, N.C.
605. Park View Hospital, Rocky Mount, N.C.
606. Rutherford Hospital, Rutherfordton, N.C.
607. Babies Hospital, Wilmington, N.C.
608. City Hospital, Winston-Salem, N.C.
609. North Carolina Baptist Hospital, Winston-Salem, N.C.

NORTH DAKOTA: 610-611

610. St. John's Hospital, Fargo, N.D.
611. Trinity Hospital, Minot, N.D.

OHIO: 612-654

612. Children's Hospital, Akron, Ohio.
613. City Hospital, Akron, Ohio.
614. Peoples Hospital, Akron, Ohio.
615. St. Thomas Hospital, Akron, Ohio.
616. Mercy Hospital, Canton, Ohio.
617. Children's Hospital, Cincinnati, Ohio.
618. Christ Hospital, Cincinnati, Ohio.
619. Cincinnati General Hospital, Cincinnati, Ohio.
620. Deaconess Hospital, Cincinnati, Ohio.
621. Dunham Hospital, Cincinnati, Ohio.
622. Good Samaritan Hospital, Cincinnati, Ohio.
623. Jewish Hospital, Cincinnati, Ohio.
624. Longview State Hospital, Cincinnati, Ohio.
625. City Hospital, Cleveland, Ohio.
626. Cleveland Clinic Foundation Hospital, Cleveland, Ohio.
627. Fairview Park Hospital, Cleveland, Ohio.
628. Glenville Hospital, Cleveland, Ohio.
629. Grace Hospital, Cleveland, Ohio.
630. Mount Sinai Hospital, Cleveland, Ohio.
631. St. Alexis Hospital, Cleveland, Ohio.
632. St. John's Hospital, Cleveland, Ohio.
633. St. Luke's Hospital, Cleveland, Ohio.
634. St. Vincent Charity Hospital, Cleveland, Ohio.
635. University Hospitals, Cleveland, Ohio.
636. Woman's Hospital, Cleveland, Ohio.
637. Children's Hospital, Columbus, Ohio.
638. Columbus State Hospital, Columbus, Ohio.
639. Franklin County Tuberculosis Hospital, Columbus, Ohio.
640. St. Francis Hospital, Columbus, Ohio.
641. Starling-Loving University Hospital, Columbus, Ohio.
642. White Cross Hospital, Columbus, Ohio.
643. Miami Valley Hospital, Dayton, Ohio.
644. Huron Road Hospital, East Cleveland, Ohio.
645. Mansfield General Hospital, Mansfield, Ohio.
646. Massillon State Hospital, Massillon, Ohio.
647. Maumee Valley Hospital, Toledo, Ohio.
648. Mercy Hospital, Toledo, Ohio.
649. St. Vincent's Hospital, Toledo, Ohio.
650. Toledo Hospital, Toledo, Ohio.
651. Sunny Acres, Cuyahoga County Tuberculosis Hospital, Warrensville, Ohio.
652. Harding Sanitarium, Worthington, Ohio.
653. St. Elizabeth's Hospital, Youngstown, Ohio.
654. Youngstown Hospital, Youngstown, Ohio.

[Continued on page 179]

Dead Giveaway

At 4 A.M. the interne phoned me: Would I come over and help him get a post-mortem permission from Mr. Z's brother, the only living relative? It was now or never, for the brother was leaving for the West Coast in a few hours. Naturally, I hurried over, since Mr. Z was a malignancy case we were anxious to study. In the hall just outside the room door I met the brother, a little fellow who listened to me with his head cocked to one side. At great length I explained why the autopsy was so important to him and to mankind. When I had eventually finished, he put a patronizing hand on my shoulder and said, "Look, why don't you ask my brother?" As he spoke, he pointed. The "dead man," in bed, was gazing balefully at me through the open doorway.

—JOHN ENGLISH, M.D.

From the Menarche to the Menopause . . .

Woman requires

4 times as much iron

Women's iron reserves are subject to constant demands. Dameshek** states, "Chronic hypochromic anemia is far more frequent in women than in men, probably because of . . . the monthly loss of appreciable quantities of blood . . . and the loss of hemoglobin-building substances to the fetus in pregnancy."

as man.*

Many iron-deficiency anemias in women can be avoided if routine prophylactic doses of iron are given whenever an excessive drain upon iron reserves is suspected.

FEOSOL TABLETS and FEOSOL ELIXIR, in the recommended dosage, achieve the two essential objectives of iron therapy: rapid hemoglobin regeneration and prompt reticulocyte response.

Smith, Kline & French Laboratories
Philadelphia, Pa.

FEOSOL TABLETS

the standard forms of iron therapy

FEOSOL ELIXIR

*Clarke, B. G.: New England J. Med. **227**:338, 1942

Dameshek, W.: New England J. Med. **232:250, 1945

OKLAHOMA ; 655-658

655. Bone and Joint Hospital-McBride Clinic, Oklahoma City, Okla.

656. St. Anthony Hospital, Oklahoma City, Okla.

657. University Hospitals, Oklahoma City, Okla.

658. Mercy Hospital for Crippled Children, Tulsa, Okla.

OREGON ; 659-664

659. Emanuel Hospital, Portland, Ore.

660. Good Samaritan Hospital, Portland, Ore.

661. St. Vincent's Hospital, Portland, Ore.

662. Shriners Hospital for Crippled Children, Portland, Ore.

663. University of Oregon Medical School Hospitals and Clinics, Portland, Ore.

664. Oregon State Hospital, Salem, Ore.

PENNSYLVANIA ; 665-720

665. Abington Memorial Hospital, Abington, Pa.

666. Allentown Hospital, Allentown, Pa.

667. Sacred Heart Hospital, Allentown, Pa.

668. St. Luke's Hospital, Bethlehem, Pa

669. Bryn Mawr Hospital, Bryn Mawr, Pa.

670. Danville State Hospital, Danville, Pa.

671. George F. Geisinger Memorial Hospital, Danville, Pa.

672. Eagleville Sanatorium for Consumptives, Eagleville, Pa.

673. State Hospital for Crippled Children, Elizabethtown, Pa.

674. Harrisburg State Hospital, Harrisburg, Pa.

675. Pittsburgh City Home and Hospitals, Mayview, Pa.

676. Norristown State Hospital, Norristown, Pa.

677. American Oncologic Hospital, Philadelphia, Pa.

678. Babies' Hospital, Philadelphia, Pa.

679. Children's Hospital, Philadelphia, Pa.

680. Children's Hospital of the Mary J. Drexel Home, Philadelphia, Pa.

681. Friends Hospital, Philadelphia, Pa.

682. Germantown Dispensary and Hospital, Philadelphia, Pa. [Cont. on page 182]

Prognosis
Life Expectancy

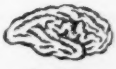
During the last decade, a growing understanding of the underlying mechanism of cardiac disease—and, as a result, improvement in the therapeutic regimen, have happily doubled the average life expectancy for the angina pectoris patient.

THEORATE (Robins)—containing theobromine (for long lasting myocardial stimulation, vasodilation and diuresis) and minimal phenobarbital posology (for central sedation and maximum synergism)—has proved remarkably beneficial in the following types of cases: angina pectoris, congestive heart failure, coronary artery disease, arterial hypertension, thyrotoxic cardiac disease, and cardiac edema. • Each enteric coated tablet (to protect against gastric irritation) contains: theobromine 5 grs., phenobarbital ¼ gr. Dosage: Two to four tablets daily after meals.

THEORATE *Robins*


Myocardial Stimulant +

Vasodilator +

Diuretic +

Sedative

PENNSYLVANIA; 665-720 (Continued)

683. Graduate Hospital of the University of Pennsylvania, Philadelphia, Pa.
684. Hahnemann Hospital, Philadelphia, Pa.
685. Hospital of the Protestant Episcopal Church, Philadelphia, Pa.
686. Hospital of the University of Pennsylvania, Philadelphia, Pa.
687. Hospital of the Woman's Medical College, Philadelphia, Pa.
688. Institute of the Pennsylvania Hospital, Philadelphia, Pa.
689. Jeanes Hospital, Philadelphia, Pa.
690. Jefferson Medical College Hospital, Philadelphia, Pa.
691. Jewish Hospital, Philadelphia, Pa.
692. Lankenau Hospital, Philadelphia, Pa.
693. Mount Sinai Hospital, Philadelphia, Pa.
694. Pennsylvania Hospital, Philadelphia, Pa.
695. Pennsylvania Hospital, Department for Mental and Nervous Diseases, Philadelphia, Pa.
696. Philadelphia General Hospital, Philadelphia, Pa.
697. Philadelphia Hospital for Contagious Disease, Philadelphia, Pa.
698. Philadelphia State Hospital, Philadelphia, Pa.
699. Presbyterian Hospital, Philadelphia, Pa.
700. St. Christopher's Hospital for Children, Philadelphia, Pa.
701. Shriners Hospital for Crippled Children, Philadelphia, Pa.
702. Skin and Cancer Hospital, Philadelphia, Pa.
703. Temple University Hospital, Philadelphia, Pa.
704. Wills Hospital, Philadelphia, Pa.
705. Woman's Hospital, Philadelphia, Pa.
706. Allegheny General Hospital, Pittsburgh, Pa.
707. Children's Hospital, Pittsburgh, Pa.
708. Elizabeth Steel Magee Hospital, Pittsburgh, Pa.
709. Eye, Ear, Nose, and Throat Hospital, Pittsburgh, Pa.
710. Mercy Hospital, Pittsburgh, Pa.
711. Montefiore Hospital, Pittsburgh, Pa.
712. Presbyterian Hospital, Pittsburgh, Pa.
713. St. Francis Hospital, Pittsburgh, Pa.
714. Western Pennsylvania Hospital, Pittsburgh, Pa.
715. Western State Psychiatric Institute and Clinic, Pittsburgh, Pa.
716. Reading Hospital, Reading, Pa.
717. Robert Packer Hospital, Sayre, Pa.
718. Warren State Hospital, Warren, Pa.
719. White Haven Sanatorium, White Haven, Pa.
720. York Hospital, York, Pa.

RHODE ISLAND; 721-725

721. State Hospital for Mental Diseases, Howard, R.I.
722. Butler Hospital, Providence, R.I.
723. Charles V. Chapin Hospital, Providence, R.I.
724. Rhode Island Hospital, Providence, R.I.
725. State Sanatorium, Wallum Lake, R.I.

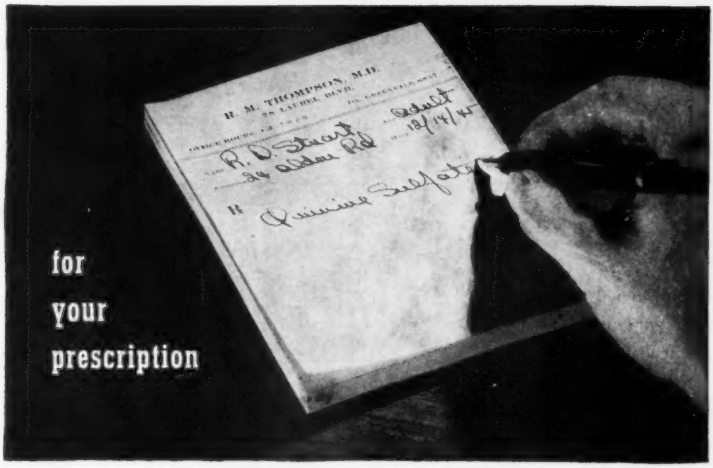
SOUTH CAROLINA; 726-727

726. Roper Hospital, Charleston, S.C.
727. Shriners Hospital for Crippled Children, Greenville, S.C.

TENNESSEE; 728-743

728. Baroness Erlanger Hospital, Chattanooga, Tenn.
729. Pine Breeze Sanatorium, Chattanooga, Tenn.
730. T. C. Thompson Children's Hospital, Chattanooga, Tenn.
731. Knoxville General Hospital, Knoxville, Tenn.
732. Baptist Memorial Hospital, Memphis, Tenn.
733. John Gaston Hospital, Memphis, Tenn.
734. Memphis Eye, Ear, Nose and Throat Hospital, Memphis, Tenn.
735. St. Joseph Hospital, Memphis, Tenn.
736. Methodist Hospital, Memphis, Tenn.
737. Willis C. Campbell Clinic, Memphis, Tenn.

[Continued on page 186]



QUININE *IS AGAIN AVAILABLE*

RESERVED exclusively for the use of our Armed Forces throughout the War, Quinine has now been released for civilian use as an antimalarial and therapeutic agent.

Merck & Co., Inc. contributed to the Wartime quinine program by supplying a substantial part of the Government's stock-pile from our reserve stocks. We also expanded our production facilities and continued the manufacture of Quinine and other Cinchona Salts for our Armed Forces and essential public health needs throughout the War.

We are pleased that we can again make Quinine available to the physician for the treatment of malaria and other conditions in which it has proved so effective.

MERCK
MERCK
MERCK
PRESCRIPTION
CHEMICALS

MERCK & CO., Inc. *Manufacturing Chemists* **RAHWAY, N. J.**

Obstructing effects upon patients' working conditions, caused by disturbing SKIN IRRITATIONS may often be eased by the use of MAZON. Its record of success in relieving obstinate skin disorders, suggests your own trial.

MAZON

Indications include Eczema, Psoriasis, Alopecia, Ringworm, Dandruff, Athlete's Foot and other skin irritations not caused by or associated with systemic or metabolic disease. Mazon is anti-pruritic, anti-septic, anti-parasitic. It is easy to apply and requires no bandaging.

BELMONT LABORATORIES CO., PHILADELPHIA, PA.

MOIST HEAT THERAPY

IN conditions which require Moist Heat applications—but no specialized nursing care—an ANTIPHLOGISTINE poultice is indicated.

This ready-to-use medicated poultice is applied comfortably hot directly to the affected area. It maintains Moist Heat for many hours.

The comforting Moist Heat of an ANTIPHLOGISTINE pack is effective in relieving the pain, swelling, and muscle spasms due to sprains, strains and contusions.

It is likewise effective in affections of the respiratory system; in relieving the cough, soreness, tightness of the chest, muscular and pleuritic pain.

ANTIPHLOGISTINE may be used with chemo-therapy.

Formula: Chemically pure Glycerine 45.000%, Iodine 0.01%, Boric Acid 0.1%, Salicylic Acid 0.02%, Oil of Wintergreen 0.002%, Oil of Peppermint 0.002%, Oil of Eucalyptus 0.002%, Kaolin Dehydrated 54.864%.

THE DENVER CHEMICAL MFG. CO., INC.
New York 13, N. Y.

Antiphlogistine

TENNESSEE; 728-743 (Continued)

738. Davidson County Tuberculosis Hospital, Nashville, Tenn.
739. George W. Hubbard Hospital of Meharry Medical College, Nashville, Tenn.
740. Nashville General Hospital, Nashville, Tenn.
741. Protestant Hospital, Nashville, Tenn.
742. St. Thomas Hospital, Nashville, Tenn.
743. Vanderbilt University Hospital, Nashville, Tenn.

TEXAS; 744-760

744. Baylor University Hospital, Dallas, Tex.
745. Children's Medical Center, Dallas, Tex.
746. Medical Arts Hospital, Dallas, Tex.
747. Parkland Hospital, Dallas, Tex.
748. St. Paul's Hospital, Dallas, Tex.
749. Texas Scottish Rite Hospital for Crippled Children, Dallas, Tex.
750. All Saints Hospital, Fort Worth, Tex.
751. U.S. Public Health Service Hospital, Ft. Worth, Tex.
752. John Sealy Hospital, Galveston, Tex.
753. St. Mary's Infirmary, Galveston, Tex.
754. Hermann Hospital, Houston, Tex.
755. Jefferson Davis Hospital, Houston, Tex.
756. Methodist Hospital, Houston, Tex.
757. St. Joseph's Infirmary, Houston, Tex.
758. Southern Pacific Hospital, Houston, Tex.
759. Woodmen of the World War Memorial Hospital, San Antonio, Tex.
760. Scott and White Hospital, Temple, Tex.

UTAH; 761

761. Salt Lake County General Hospital, Salt Lake City, Utah.

VERMONT; 762

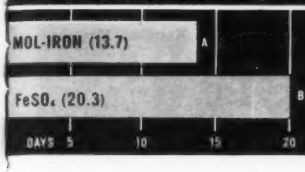
762. Mary Fletcher Hospital, Burlington, Vt.

VIRGINIA; 763-775

763. University of Virginia Hospital, Charlottesville, Va.
764. Chesapeake and Ohio Hospital, Clifton Forge, Va.
765. Elizabeth Buxton Hospital, Newport News, Va.
766. Riverside Hospital, Newport News, Va.
767. Norfolk General Hospital, Norfolk, Va.
768. Grace Hospital, Richmond, Va.
769. Johnston-Willis Hospital, Richmond, Va.
770. Medical College of Virginia Hospital Div., Richmond, Va.
771. Retreat for the Sick, Richmond, Va.
772. St. Elizabeth's Hospital, Richmond, Va.
773. Sheltering Arms Hospital, Richmond, Va.
774. Gill Memorial Hospital, Roanoke, Va.
775. Jefferson Hospital, Roanoke, Va.

[Continued on page 188]

Rapidity of Clinical Response



(A) Completely effective therapeutic response (return to normal blood values) was obtained in an average of 13.7 days of Mol-Iron therapy.

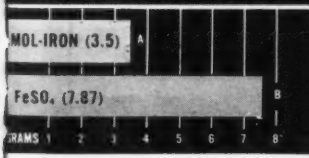
(B) Ferrous sulfate therapy *failed* to produce normal hemoglobin values after an average of 20.3 days.

Average Daily Hemoglobin Increase

(A) The group treated with Mol-Iron averaged a daily hemoglobin increase of 2.48 per cent (0.36 Gm. per cent).

(B) The group treated with ferrous sulfate showed an average daily gain of hemoglobin of 0.83 per cent (0.12 Gm. per cent)—a response about one-third as effective.

Therapeutic Intake of Bivalent Iron



(A) The Mol-Iron treated group received an average total of 3.528 Gms. of bivalent iron to produce the sought for result (return to normal blood values).

(B) While an average ingestion of 7.871 Gms. of bivalent iron failed to achieve an optimal response in the ferrous sulfate treated group.

The charts summarize the results of a controlled study of comparative therapeutic response in post-hemorrhagic and nutritional hypochromic anemias.

The series includes 49 cases treated with Mol-Iron and 21 with exsiccated ferrous sulfate; the results are typical of those observed in treatment of iron-deficiency anemias with White's Mol-Iron.

A DEFINITE ADVANCE IN TREATMENT OF HYPOCHROMIC ANEMIA

White's MOL-IRON TABLETS

As compared with ferrous sulfate given in equivalent dosage—

1. Normal hemoglobin values are found to be restored more rapidly with White's Mol-Iron. Daily rate of hemoglobin formation may be *increased as much as 100% or more.*
2. Iron utilization is similarly more complete.
3. Gastrointestinal tolerance is notably satisfactory—even where other iron preparations have previously been poorly tolerated.

INDICATIONS: Hypochromic (iron-deficiency) anemias caused by inadequate dietary intake or impaired intestinal absorption of iron; excessive utilization of iron, as in pregnancy and lactation; chronic hemorrhage.

DOSAGE: One or two tablets three times daily after meals.

Available in bottles of 100 and 1000 tablets.

Ethically promoted—not advertised to the laity.

PHARMACEUTICAL White LABORATORIES, INC. NEWARK 7, N. J. MANUFACTURERS

WASHINGTON; 776-786

776. Western State Hospital, Ft. Steilacoom, Wash.

777. Eastern State Hospital, Medical Lake, Wash.

778. Children's Orthopedic Hospital, Seattle, Wash.

779. King County Hospital, Seattle, Wash.

780. Maynard Hospital, Seattle, Wash.

781. Providence Hospital, Seattle, Wash.

782. Swedish Hospital, Seattle, Wash.

783. Virginia Mason Hospital, Seattle, Wash.

784. Northern State Hospital, Sedro Woolley, Wash.

785. Tacoma General Hospital, Tacoma, Wash.

786. Northern Permanente Foundation, Vancouver, Wash.

WEST VIRGINIA; 787-795

787. Beckley Hospital, Beckley, W. Va.

788. Charleston General Hospital, Charleston, W. Va.

789. McMillan Hospital, Charleston, W. Va.

790. St. Francis Hospital, Charleston, W. Va.

791. St. Mary's Hospital, Clarksburg, W. Va.

792. Hopemont Sanitarium, Hopemont, W. Va.

793. Chesapeake and Ohio Hospital, Huntington, W. Va.

794. St. Mary's Hospital, Huntington, W. Va.

795. Laird Memorial Hospital, Montgomery, W. Va.

WISCONSIN; 796-808

796. Mercy Hospital, Janesville, Wis.

797. La Crosse Lutheran Hospital, La Crosse, Wis.

798. State of Wisconsin General Hospital, Madison, Wis.

799. Columbia Hospital, Milwaukee, Wis.

800. Milwaukee Children's Hospital, Milwaukee, Wis.

801. Milwaukee County Hospital, Milwaukee, Wis.

802. Milwaukee County Hospital for Mental Diseases, Milwaukee, Wis.

803. Muirdale Sanatorium, Milwaukee, Wis.

804. St. Joseph's Hospital, Milwaukee, Wis.

805. St. Luke's Hospital, Milwaukee, Wis.

806. Wisconsin State Sanatorium, Statesan, Wis.

807. St. Mary's Hospital, Superior, Wis.

808. Milwaukee Sanitarium, Wauwatosa, Wis.

CANAL ZONE; 809

809. Gorgas Hospital, Ancon, C.Z.

HAWAII; 810

810. Queens Hospital, Honolulu, Hawaii.

The Newsvane

M.D.'s Get Clerical Help

Realizing that many physician-veterans entering private practice could make use of a part-time secretary, the business bureau of the Milwaukee County Medical Society has provided its returning members with a stenographic-secretarial service available on an hourly or daily basis. The bureau is prepared to furnish whatever kind of clerical assistance is needed in bookkeeping, mailing of bills and statements, filing of reports, letter writing, and the collection of overdue accounts. As a part of the service, such accounts are segregated and brought to the doctor's attention when statements are being prepared.

Urges Tax-Relief Bill for Physicians

If Representative Clare Boothe Luce (R., Conn.) has her way, members of the medical and dental professions will be granted an income-tax exemption for time spent in providing services for which they receive no pay. A measure to this effect has been introduced in the House by Mrs. Luce, who told her colleagues that such action would be one way to restore the medical profession to its privileged place in the community and to attract the necessary number of young men and women to its ranks.

According to the Congresswoman, surveys show that from 30 to 45 per cent of all treatments given are not paid for. This was in addition to the "hours spent without pay in public research work, on hospital boards and boards of charitable organizations," she said. "All this must be chalked up to professional devotion."

Says Osteopaths, Cultists Exploited Emergency

Deploring the fact that osteopaths, naturopaths, and chiropractors were able to capitalize on the emergency by keeping practically all their men out of service and yet make it appear that they were being discriminated against because they were ineligible for commissions, Dr. J. J. Lightbody, editor of the Detroit Medical News, believes that their increased numbers now account, in large measure, for the fact that physician-veterans find it extremely difficult to obtain office space. Later, he says, these same "ill-begotten bed fellows" may cause a shortage of patients in veterans' offices.

"Some believe that these groups have gone so far that it will be necessary for the recognized pro-

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says a New York Physician

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fession to absorb them," the editor goes on to say. "Who said they wanted to be absorbed? The chiropractors are considering absorbing the naturopaths, the osteopaths are considering absorbing the chiropractors, the doctors of medicine are considering absorbing the osteopaths, and the Government is considering absorbing us—which practically ruins our absorption coefficient."

Hospital's Tax Claim Upheld by Court

After five years' litigation, the New York Court of Appeals has upheld Doctors Hospital, New York City, in its claim to tax exemption for its real estate. Reliable opinion is that the decision will have a far-reaching effect in establishing the right of other institutions to similar exemption.

Earlier judgments in the case had held that the amount of free care rendered by the hospital did not entitle it to exemption under statute requirements. In upholding the institution, the Court of Appeals affirmed, without opinion, a decision of the Appellate Division of the Supreme Court which held that if exemption were based upon such a condition, city officials would possess a discretionary power that would make the state tax law meaningless.

The Appellate Division ruled that "Hospitals which are devoted to the care of the sick and injured, which aid in maintaining public health, and which make valuable contributions to the advancement of medical science, are rightly regarded as benevolent and charitable. A hospital association not conducted for profit, which devotes all its funds exclusively to the maintenance of the institution, is a public charity; and this is so irrespective of whether patients are required to pay for services rendered."

Fishbein, Deutsch Agree

Morris Fishbein and Albert Deutsch, rarely on the same side in any argument, agreed recently that the title "doctor" should be restricted to doctors of medicine, thus preventing confusion in the minds of the public. To Deutsch's own paper, PM, came a biting rebuttal from an anonymous "university professor" who wrote: "We can understand Fishbein's concern, because

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FORMULAC is the trade-name for a new product —a reduced milk in liquid form—supplemented with vitamins and minerals to render it an adequate food for infants.

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FORMULAC, newly introduced on the market, is promoted ethically.

FORMULAC, supplemented by carbohydrates at your discretion, presents a flexible basis for formula preparation, readily adjustable to each individual child's needs.

FORMULAC has been tested clinically, and proved satisfactory in promoting infant growth and development. Priced within range of even low income groups, this inexpensive infant food is on sale at most drug and grocery stores.

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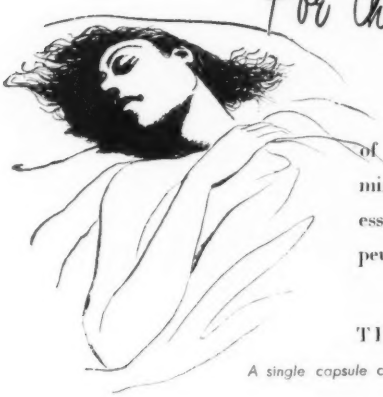

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Vitamin A	25,000 units
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Riboflavin	5 mg.
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Ascorbic Acid	75 mg.

SQUIBB . . . MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

And protection too...

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By spray, drops or tamponage, Sulmefrin affords the benefits of sodium sulfathiazole anhydrous 1.25% and sodium sulfadiazine 1.25% with the safe decongestant properties of 0.125% *dl*-desoxyephedrine hydrochloride in a stabilized aqueous vehicle.

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Constipation in "Bed Rest" Patients

Rest—essential treatment of pulmonary tuberculosis—deprives the body of the usual exercise which helps maintain bowel tone and facilitates normal movements, and it is customary to find constipation in those on complete bed rest.

The pleasant taste of Kondremul makes it acceptable to the most finicky tastes; its fine emulsion prevents gas formation and cramps; it does not leak from the anus as does plain mineral oil, thus avoiding linen soilage and patient embarrassment.

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there is no group of doctors who are so jealous of their titles as the medicos. There is no profession that attempts to arrogate to itself, as its own exclusive property, any and everything with which it has been associated. . . But surely Mr. Deutsch knows that from the Middle Ages the word 'doctor' has meant, first of all, a master teacher, one competent to teach, and that it is a title subsequently taken and claimed by the medicos. . . Thus, if anyone should be apologetic, it is the physicians, not the Ph.D. holders."

Auto Phones Next Step For Physicians

Auto phones were being tested last month by the Bell System over three busy highways between Chicago and St. Louis, New York and Buffalo, and New York and Boston; and the final step—installation of telephone instruments in the cars of physicians and other busy Americans—was not far off. Using a combination of radio and land lines, special phone operators will be able to effect a quick connection between a physician or other traveler and any conventional land instrument. If a doctor moving about on his calls wants to get in touch with his secretary, he will lift a telephone instrument from its cradle on his dashboard, press a "talk" button to summon the operator, and give his number. From that point on, the call will resemble the conventional one very closely, except that the user of the auto instrument will have to press the "talk" button when he wishes to switch from listening to speaking. Calls from land stations will be handled in much the

same way, with visual and audible signals indicating to the motorist that he is wanted.

Praise Private Companies' Penicillin Research

An example of the patriotic contribution made during the war by commercial pharmaceutical and chemical companies was cited last month by Dr. Vannevar Bush, director of the Office of Scientific Research and Development. He revealed that a secret war research effort to synthesize penicillin had been made possible largely through the work and financial support of these companies, which had spent no less than $2½ million of their own funds on the experiment (five times what the Government spent).

Dr. Bush placed particular emphasis on the fact that the companies had made a large investment in a synthesizing project which, if successful, would have rendered valueless their even larger investment in facilities for producing natural penicillin. He also pointed out that the commercial companies had agreed to allow the OSRD to turn over to their competitors valuable data which each concern had obtained through its own research and that they had further agreed to let the OSRD use its own judgment in disposing of patent rights originating in the program.

"Although the program, originally intended because of the then limited output of natural penicillin, did not result in development of a commercially feasible method of synthesizing penicillin, it did result

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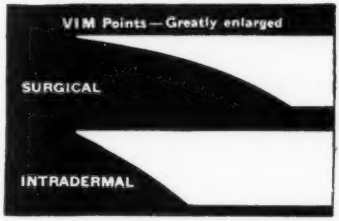

Order VIM from your surgical instrument dealer—he has ample stocks of favored gauges and lengths for Immunization work. Write us for full list of VIM sizes for general Hypo. Subcutaneous, Intravenous, and Intramuscular work.

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in substantial progress in a new and important field of medical research, and disclosed several artificially produced penicillins of potential value," Dr. Bush said.

He added that "The progress made and the unique degree of cooperation shown by the commercial firms are a landmark in the already bright history of industrial cooperation with the Government in wartime research."

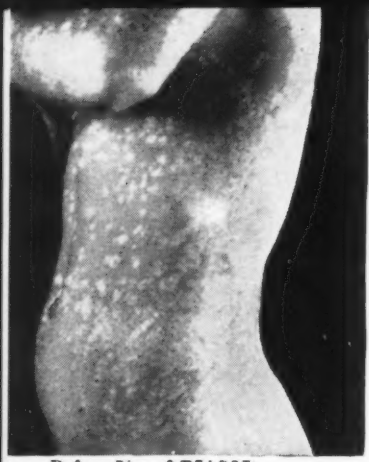
Radiologists Get Low-Cost Liability Policy

Malpractice insurance, providing comprehensive coverage at low cost, has been made available to members and fellows of the American College of Radiology by its board of chancellors, working in conjunction with the St. Paul Mercury Indemnity Company, which is licensed in all states. Beside offering considerable savings in premiums, says the ACR, the new policy is superior to others in that it guarantees to pay, without exclusions, "all loss by reason of the liability imposed by law upon the insured for damages on account of professional services rendered or which should have been rendered by him or by any assistant to him."

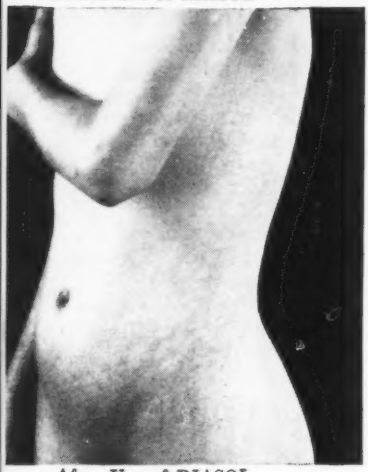
For $25,000/$75,000 coverage, civilian members of the ACR will pay $79 a year or $195 for a three-year contract. Premiums are reduced one-half for members in military service. Personal liability coverage for assistants and technicians can be purchased for 50 per cent of the premium for each one named.

In announcing the new policy, the ACR declared that radiologists have been increasingly dissatisfied with the cost and coverage of malpractice insurance. It said that a special policy, drawn up ten years ago by Lloyds and offered to members of the American Roentgen Ray Society, the Radiological Society of North America, and the American College of Radiology, "filled a real need at the time but in subsequent years has gone through progressive changes that rather thoroughly vitiated it." Premiums were gradually increased," explained the ACR, "until they reached $90 a year. About four years ago, rates for the ten western states were increased to $366 per year for $25,000/$75,000 limits. Later, liability for alleged injuries resulting from fluoroscopy was limited to $2,500 in any one year, with the insured

[*Continued on page* 206]



Before Use of RIASOL



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RIASOL's low surface tension enables it to reach and *act upon* the inflamed lower layers while scale removal and cosmetic relief are still in progress.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply RIASOL daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages needed. After one week, adjust to the patient's progress. RIASOL may be applied to any area, including face and scalp.

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Anecdotes

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required to pay $500 of that. On October 1, 1945, rates were sharply increased for most of the remaining 38 states—in some, as much as 300 per cent."

Lloyds' Chicago agent, said the college, admitted that the increase was based upon the underwriters' general experience in medical malpractice insurance, not upon its experience with radiologists only.

Chiropractor's Testimony Called 'Misleading'

Statements made before a Congressional subcommittee by John H. Nugent, educational director of the National Chiropractic Association, about his status on the Connecticut State Board of Healing Arts have been called "inaccurate and wholly misleading" by Prof. C. M. Bakewell, the board's chairman. The challenged Nugent statements were made in the course of testimony on Connecticut's basic science law, in which he was attempting to show that it set up similar standards for doctors of medicine and chiropractors.

"I wrote that statute myself in 1924," Nugent told a subcommittee of the Senate Committee on Education and Labor. "To be honest, I was sick and tired of having our medical brethren tell me that I was not as well qualified as they were, so I said, 'We will put an end to this. We will all take the same examination.'"

Describing procedure under the law, Nugent said that chiropractors "come before a board of examiners . . . composed of Professor Bakewell of Yale University, a judge of one of the municipal courts, and an in-

SCIENCE OR SORCERY ?

Oh, the gnawing, nauseous, digestion-mocking torment of a peptic ulcer! And the gratitude of its victim released from the wearisome pain and back to a full diet! His doctor is viewed as something between a scientist and a sorcerer.

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In fixing hydrochloric acid with aluminum hydroxide, oxychlorides are formed. There is no rebound of acids. Because of the mild astringency of these substances bleeding tends to be arrested; healing of ulcers promoted.

The alkaline secretions of the intestine reconvert the oxychlorides to insoluble aluminum compounds. The chloride ion, being soluble, is reabsorbed into the blood stream. The aluminum compounds are excreted.

Your Breon technical service man will tell you other interesting things about *Fluagel, the fluid aluminum hydroxide.*

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- The emulsion flows smoothly and freely through the needle;
- Time-saving for the physician;
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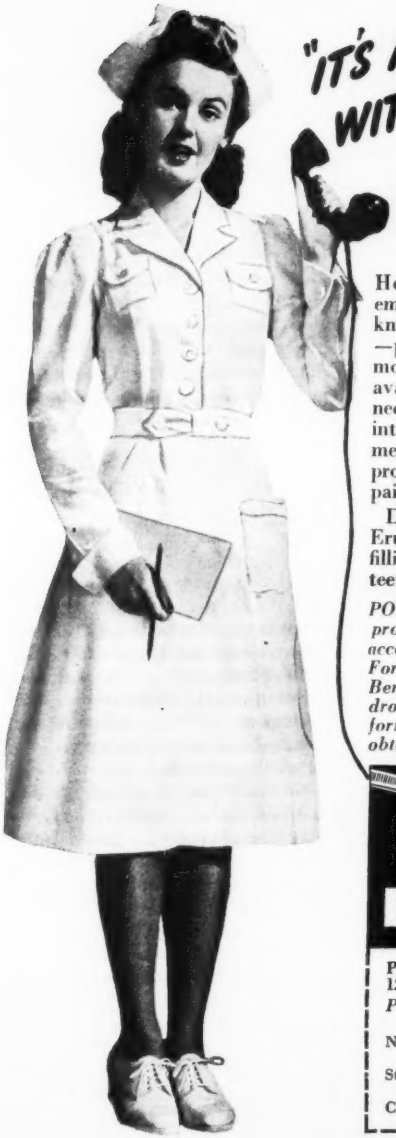

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DOCTOR, has this ever happened to you?

Here's a suggestion, Doctor—treat emergency dental pain with the well-known POLORIS DENTAL POULTICE —provides prompt, safe relief until more complete dental treatment is available—usually eases pain without need for opiates or sedatives—will not interfere with subsequent dental treatment. For over 30 years the dental profession has prescribed POLORIS for pain caused by:

Dental abscess • Pain after extraction • Erupting third molar • Irritation after filling • Other painful conditions of the teeth and gums not due to cavity.

POLORIS is a scientifically tested and proven dental aid . . . acts on medically accepted principle of counter-irritation. Formula consists of Capsicum, Hops, Benzocaine, Sassafras Root and Hydroxyquinoline Sulfate in poultice form. Never advertised to the public—obtainable at all drug stores.

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dustrialist. The reason I set it up that way was that this board should be nonprofessional. This was done for the protection of the public.

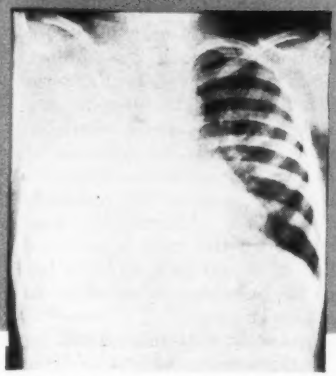
"We suggested that they employ experts; so they employed a professor from Yale who is a medical man, they employed an osteopath, and they employed me on a fee basis. . . We prepare an examination paper comprised of 100 or more questions out of which the board selects a dozen or twenty. Everyone comes in and takes the exam. Then they get the so-called experts and say, 'Here you are. What percentage should they get?' The medical man marks them, the osteopath marks them, and I mark them."

Taking up Nugent's contentions one by one, Professor Bakewell declared that the Connecticut basic science law actually stemmed from the "diploma mill" scandal which rocked the state in the early 20's and led to a sweeping investigation of licensure. A grand jury, as one of its recommendations, drew up a model basic science bill and presented it to the legislature. After hearings at which amendments and modifications were suggested, the bill was enacted.

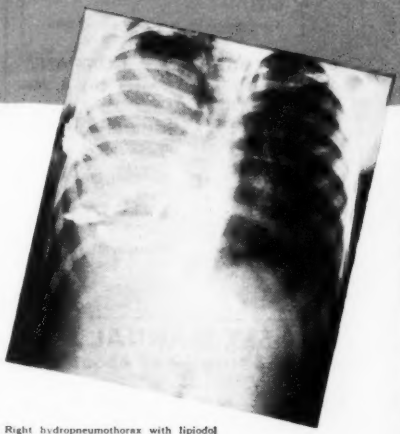
As to Nugent's statement that "We prepare an examination paper composed of 100 or more questions," Professor Bakewell said "in no case" had the board used questions prepared by Nugent. He also declared that the chiropractor's description of the three-man board was "erroneous as to two members."

Nugent had been connected with the board, said its chairman, and he explained: "It has been our habit, as a check for fairness, to have

Penicillin in Empyema

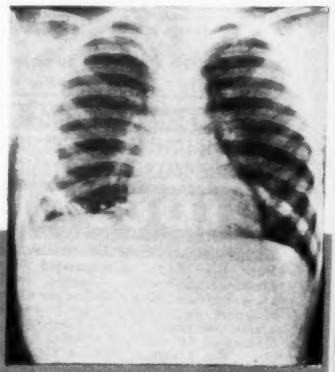


1. Right lobar pneumonia (type 1) and right empyema.



2. Right hydropneumothorax with lipiodol injections showing interlobar empyema.

3. After injecting Penicillin in saline into empyema cavity daily for five days.



Size of cavity, type of infection, and number of organisms determine the amount of penicillin to be administered in empyema. Usually 50,000 or 100,000 units in normal physiologic saline solution are injected once or twice daily directly into the empyema cavity after aspiration of pus or fluid. (Keefer, C. S., et al.: New Dosage Forms of Penicillin, J.A.M.A. 128:1161 [Aug. 18] 1945.) Treatment is by instillation, rather than irrigation, because penicillin requires at least 6 to 8 hours of contact for maximum effect.

Bristol Penicillin, because of its freedom from toxicity and pyrogens, as well as absolute sterility and standard potency assures the desired pharmacologic action.

The rapidly developing new clinical uses of this potent antibiotic are abstracted in issues of the BRISTOL PENICILLIN DIGEST. If not receiving *your copies* regularly, write.

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grades on failed papers reviewed and to include among the reviewers a representative of each group [of practitioners] among the failures. We pay the reviewers for this service. It has been interesting to note that their opinions almost invariably have agreed with the judgment of our experts, or varied so little as to make no change in the applicant's status. When chiropractors have been among the failures we have called in Dr. Nugent, and this has been the only capacity in which he has been employed."

Apparently not embarrassed by these disclosures, Nugent told the committee that he denied, "in toto," that he had made misleading statements about the procedure in Connecticut. "The Healing Arts Board called in experts, medical experts, and I said they called me in. They call me in to go over the examination papers, and I am paid by state voucher. . . This is a matter of record, Dr. Bakewell to the contrary notwithstanding. . . I have always thought of Dr. Bakewell as being a gentleman and I still think he is. But I think he is very much mistaken."

Public Health Positions Found Unattractive

The outlook for public health departments seemed dismal. The reason was simple: Older workers who had been willing to sublimate all personal ambition to the call were retiring or dying, thus thinning out ranks that had been inadequate in the beginning. And there were practically no recruits. Competition for the services of doctors, engineers, and nurses was lively. What attrac-


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tion was there in a job which paid little, offered no civil service protection, and no promise of promotion for merit?

Dr. Joseph W. Mountin, medical director of the U.S. Public Health Service, knew the score and he gave it to state and territorial health officers. Authorized to investigate the civil service or merit laws of states and territories, the USPHS had found forty-five out of fifty satisfactory. But when it examined classification systems and compensation plans, it approved only twenty. "And this," said Dr. Mountin, "is precisely where work must be done if success is to be achieved in making public health positions more attractive."

Dr. Mountin pointed out that of 21,029 medical officers queried by the AMA only 110 signified that they wanted post-war training in public health work. "Not all of these," he said, "represent an accession to this field; actually a high proportion are thus merely indicating they desire additional training before resuming their usual work. And there is no assurance that even all these will re-enter such work."

Dr. Mountin was pessimistic about immediate prospects for an increase in public health personnel. "With the exception of nurses, and possibly technicians, there just won't be any for some time. Right now there is a world-wide shortage of physicians and no one can tell when new ones will be turned out in sufficient numbers. The prospects for engineers may be somewhat better, but they are not too bright. Additional first-class research workers are not likely to become available for some time."

Public health departments must

BIOLOGICALS, BIOCHEMICALS, PHARMACEUTICALS FOR THE MEDICAL PROFESSION

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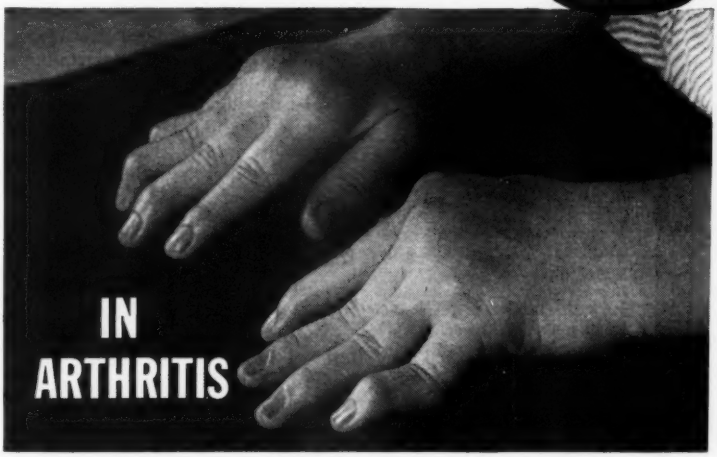

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make their jobs more attractive, he said. But how? "The principal factors that determine the attractiveness of any job seem rather obvious: financial remuneration, selection on merit, and opportunity for professional development. On these three scores, it cannot be said that public health positions have in the past invited favorable consideration, nor can it be maintained that responsible public health administrators have faced the situation frankly.

"Unfortunately there has prevailed the tradition not only of housing public health staffs in the basement but of placing them at the bottom of the salary scale. Merit as a basis for employment and promotion frequently yields to preferential treatment of one type or another. . . There has been a feeling that public health positions are in the nature of a 'call' and that no other consideration need be considered. It seems likely that with the din of industry and the jingle of coin, this 'call' will go unheard by many desirable candidates."

To put public health work on a competitive position in the personnel market, Dr. Mountin recommended:

¶ Establishment of civil service status by law or of a merit system by administrators.

¶ Generous compensation.

¶ An adequate retirement plan.

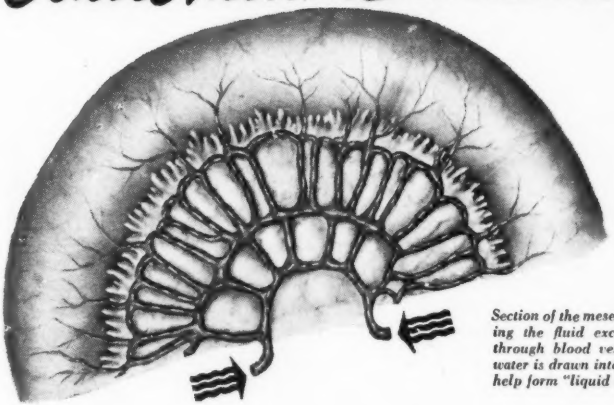
¶ Employment of competent lay persons for business administration.

¶ Wider and more intelligent use of auxiliary personnel in professional work.

¶ Establishment of suitable job registers.

¶ Reciprocity among states in accepting the credentials of candidates.

PHYSICIANS PREFER *Gentle Pressure* IN LAXATION



Section of the mesenterium showing the fluid exchange system through blood vessels whereby water is drawn into the bowel to help form "liquid bulk."

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SAL HEPATICA is simple to administer, pleasant to take, and prompt in yielding a response. Its gentle pressure can be depended on to relieve constipation without irritation.

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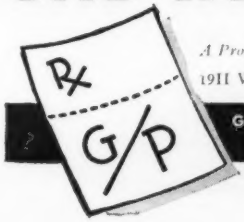

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1. COWLES, P. B.: Yale Journal of Biology and Medicine 14:399-604, July 1942.
2. TOPLEY, W. W. C., and WILSON, G. S.: The Principles of Bacteriology and Immunity, 2nd ed., Williams and Wilkins Co., Baltimore, page 44, 1936.

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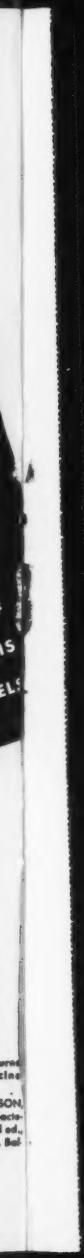

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